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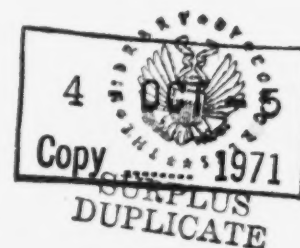
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ABSTRACT

To develop guidelines for the identification of behavioral disorders and devise more effective means for working with people classified as having behavioral disorders, a study group reviewed knowledges and experiences of group members, conducted a literature study, and surveyed 91 state vocational rehabilitation agencies with respect to: (1) guidelines directed to staff for providing services, (2) approaches followed in obtaining evaluations, (3) number of clients with behavioral disorders who were rehabilitated, (4) programs and delivery systems utilized by the agencies in serving clients, and (5) urgent needs and greatest barriers in serving clients with behavioral disorders. The survey revealed that a diversity of programs were taking place on a broad base with varying degrees of success. However, it is unclear who should properly be identified as having a behavior disorder. A review of the issues in counseling approaches suggests that the traditional approach is based upon underlying assumptions of questionable validity, and criticisms have been leveled against inappropriate use of the medical model, diagnostics, and middle-class conceptions of counseling. In terms of training needed by counselors, aides, supervisors, and administrators, several techniques based on experiences of the study group are presented. (SB)

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**ISSUES RELATING TO
REHABILITATION OF
INDIVIDUALS WITH
BEHAVIORAL DISORDERS**



SEVENTH INSTITUTE ON
REHABILITATION SERVICES



a training guide

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U.S. DEPARTMENT OF
HEALTH, EDUCATION, AND WELFARE
Social and Rehabilitation Service
Rehabilitation Services Administration

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REHABILITATION
OF
INDIVIDUALS WITH BEHAVIORAL DISORDERS

A Report from the Study Group on Rehabilitation
of Individuals with Behavioral Disorders

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The materials in this publication do not necessarily represent the official views of the Rehabilitation Services Administration nor of State vocational rehabilitation agencies. They do, however, reflect an attempt by State vocational rehabilitation workers to explore a significant aspect of their programs in order to encourage evaluation and stimulate professional growth.

FOREWORD

Revised Federal Regulations governing the vocational rehabilitation program, issued in January, 1966, included "behavioral disorders" as a physical or mental disability. Perhaps no other recent program development created as much interest--and controversy--as this addition.

This training manual was written by one of the Study Groups of the Seventh Institute on Rehabilitation Services in response to the desire of State vocational rehabilitation agencies to better understand behavioral disorders and what this provision means in terms of people to be served. Experience of the program with behavioral disorders had not been great enough at the time the present manual was written to develop, as most IRS manuals do, specific guidelines for identifying and serving individuals with behavioral disorders. However, despite the lack of resolution of this topic, discussion of issues presented in this guide will be of value as the State agencies continue to move to serving larger numbers of those with behavioral disorders.

Inserted as an addendum is a copy of a memorandum dated August 17, 1970, to each Associate Regional Commissioner for Rehabilitation Services, which conveys some of the current thinking on a number of the questions which remain.


Edward Newman
Commissioner

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CHAPTER I

SCOPE OF THE STUDY

The scope of the State-Federal Rehabilitation program has expanded and the complexity of the service process has increased. The State rehabilitation agencies have found it necessary to modify their structure and procedures for service. Expanding services is not a new concept in rehabilitation.

Rehabilitation moved rather easily, though not rapidly, from solely a physically handicapped program into the areas of mental retardation and mental illness when this was first made legal. By liberal interpretation of the law, the States have provided services to many disabled clients who might otherwise have been rejected.

Federal Regulations written following the 1965 Amendments to the Rehabilitation Act (P. L. 89-333) resulted in an expansion of the program in the direction of service to the "behaviorally disabled." "Physical or mental disability" as now defined:

"means a physical or mental condition which materially limits, contributes to limiting, or if not corrected, will probably result in limiting an individual's activities or functioning. It includes behavioral disorders characterized by a pattern of deviant social behavior or impaired ability to carry out normal relationships with family and community which may result from vocational, educational, cultural, social, environmental, or other factors."

A cursory look at this definition would make one believe that almost anyone could fall within the limits of "physical or mental disability." However, since funds are not limitless, it means that the various State agencies must be somewhat restrictive in the interpretation of this definition. What are the workable limits? How can this added extension of rehabilitation services be administered in such a manner that those who in fact need service, will receive it?

Origin of This Study

The interest on the part of the various States in reviewing eligibility, feasibility, delivery of services, just to mention a few of the areas of concern,

was evidenced in the proposals for study topics submitted to the Planning Committee for the 1969 Institute on Rehabilitation Services. A majority of the nine Rehabilitation Services Administration Regions specifically requested study of "Behavioral Disorders and the Disadvantaged."

Charges to This Study Committee

The degree of concern about this topic area was considered by the Planning Committee to be a mandate to establish a Study Group to study behavioral disorders and the disadvantaged. The purpose of this Study Group was to develop guidelines for the identification of behavioral disorders and to devise more effective means for working with people classified as having behavioral disorders.

The specific charges to the Study Group called for identification of the relationship between behavioral disorders and the culturally deprived, and to clarify vocational rehabilitation's role to other manpower subsystems. The full list of charges is listed in Appendix F.

The Study Group's Interpretation of the Charges

In order that they might devise an effective approach to the study, the members of the Study Group made their first item of business that of studying the charges. It was determined that the scope of the study suggested by the charges was greater than the time and resources available. The Group felt obligated to restrict its attention to a specific aspect of the study, or to make an interim report at the end of the year with the hope that future Planning Committees would continue the study.

The past experiences of other study groups and the unmanageable scope of the charges to this Study Group were paramount in the ultimate decision to limit this study to that aspect of the charges relating to the definition and identification of behavioral disorders, the provision of services to this group, and to disregard the larger problem of the disadvantaged except where the problems of these two groups are common.

As illustrative of the multiplicity of problems that could confront this Study Group, one needs only to look at the definition of "disadvantaged" as cited in the 1968 Amendments to the Vocational Rehabilitation Act (P. L. 90-391).

"As used in this section, the term 'disadvantaged individual' means (i) handicapped individuals as defined in Sec. 11(b) of this act, (ii) individuals disadvantaged by reason of their youth, or advanced age, low educational attainments, ethnic or cultural factors, prison and delinquency records, or other conditions which constitute a barrier to employment, and (iii) other members of their families when the provision of vocational rehabilitation services to family members is necessary for the rehabilitation of an individual described in clause (i) or (ii)."

The 1968 Amendments came at a time of rapid change, when the rehabilitation program was reaching out to serve large numbers of additional persons. This definition was immediately seen as demonstrating that a physical or mental disability was no longer necessary in order to serve individuals. Unfortunately, the definition of disadvantaged was not always seen in its true context: that a totally new program was being authorized--work evaluation and work adjustment services for the non-disabled--separate and apart from the on-going rehabilitation program.

Federal Regulations require that, "In all cases of behavioral disorders a psychiatric or psychological evaluation will be obtained, as appropriate."

Does this mean, then, that in order to serve this group of our society we must add to their "disability" by giving them a psychological or psychiatric label? Such an additional label might appear even more threatening to them or to a prospective employer than the client's basic problem of previous incarceration, school drop out, or whatever. With the shortage of qualified psychologists and psychiatrists does the necessity for this type of evaluation preclude rehabilitation services at an early stage when they might be most beneficial?

Issues Considered in the Study

The Study Group was determined to produce material that was functional and that would provide helpful guidance to rehabilitation agencies--supervisors, counselors, aides--as they attempt to serve the disability group known as the behaviorally disordered.

Through review of the knowledges and experiences of the members of the Study Group, by study of the literature, and by study of State agencies' responses to inquiry, an effort was made to identify the issues that seemed most related to serving this disability group. The Study Group determined that if it were to fulfill the charges as interpreted by the Group, it must

devote significant attention to:

- a. The definition of what is a behavioral disorder.
- b. Training of counselors and supervisors. What specific types of training are needed? Is the type of training needed the same for counselors and supervisors, or does it differ? Can this training need best be met by in-service training, or is it better handled by out-service training?
- c. Appropriate delivery systems. Can the job be performed satisfactorily by utilizing the traditional delivery systems, or must we devise better and faster means of delivering services?
- d. Identification and evaluation techniques. How do we identify the person with a behavioral disorder? How do we evaluate his potential? What are the best known techniques, and what are the strengths and weaknesses of these techniques?
- e. Qualification of personnel making eligibility decisions. The determination of eligibility must remain in the counselor's hands. What type of consultative personnel can help him to make the most appropriate decisions? What type training--minimum--must these consultants possess? In view of the written law, coupled with shortages of psychologists and psychiatrists, how can we best utilize the professional personnel available to us?
- f. Counselor and community attitude. How can we change negative attitudes of counselors and the community? This is not to say that all counselors have negative attitudes, nor is it to say that all community attitudes are negative. Rather, it is recognizing that much of our difficulty in working with this behaviorally disordered group is going to be one of creating favorable attitudes.
- g. Agency attitude. Above, we recognized that in many instances it is the attitude of the individual counselor working in the community that creates the block to rehabilitation. Here, we are considering the reluctance of the agency administration to give more than lip service to the rehabilitation of the behaviorally disordered.
- h. Implications for the future. Here we want to look at the changes that must come about--whether that means changes in legislation, changes in the rehabilitation concept, or changes in society, itself. How can we facilitate the changes that are needed?

It is acknowledged that the position taken and the recommendations made in the subsequent chapters may be incomplete and will most surely be controversial. It is hoped that they will not be inadequate. It is hoped that they will be functional. They are offered with the intention of making better services available to a group in our society that has traditionally been neglected.

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CHAPTER II

HISTORICAL BACKGROUND AND LEGAL FRAMEWORK

Some Historical Background

The 1965 Amendments to the Vocational Rehabilitation Act marked the first major change in rehabilitation legislation since 1954. Among the landmarks blazed by the 1965 Amendments were the raising of the Federal matching rate to a flat 75 per cent, special projects to increase the number of severely disabled who are rehabilitated, comprehensive Statewide Planning for the orderly development of rehabilitation resources both public and private, and the provision of a period of extended evaluation before requiring a decision of probable outcome of a course of rehabilitation.

The changes authorized by the 1965 Amendments were such that a revision of the Federal Regulations governing the rehabilitation program was required. In the revised regulations, new language was inserted to make clear that the State-Federal program was intended to serve the more difficult client. Especially significant was a clarification added to the definition of physical or mental disability that referred to behavioral disorders:

"Physical or mental disability means a physical or mental condition which materially limits, contributes to limiting, or, if not corrected, will probably result in limiting an individual's activities or functioning. It includes behavioral disorders characterized by deviant social behavior or impaired ability to carry out normal relationships with family and community which may result from vocational, educational, cultural, social, environmental, or other factors." Section 401.1 (o).*

The expanded definition of physical disability, and the revised definition of "substantial handicap to employment" were immediately seen as encouraging the provision of rehabilitation services to additional numbers of disabled persons. Lamborn, writing in the Rehabilitation Record, publication of the Rehabilitation Services Administration, stated, "No longer can (the applicant) be excluded because the cause of the disability is rooted in poverty or cultural deprivation rather than in disease, or accident, or a congenital defect" (Lamborn, 1966).

*Regulations were renumbered following the 1968 Amendments to the Vocational Rehabilitation Act. Citations in this document reflect the numbering system current at the time of publication.

The new Regulations departed from previous practice by linking some possible causes for a particular disability type to the definition of the disability. This, plus the attention to environmental factors exacerbating the impact of the disability on the individual, led to the assumption that the possible causative factors were the disability. The logical conclusion, once the erroneous assumption was made, was that the State-Federal program of rehabilitation could serve persons classified as disadvantaged because of the disadvantage.

The revised Regulations were issued following the 1965 Amendments, and were occasioned by the changes in the program initiated by the Amendments. Again, a false assumption was made that the inclusion of behavioral disorders was a new class of disability written into the rehabilitation program by the 1965 Amendments.

One additional new provision of the revised Regulations acknowledged the influence of factors other than functional limitations on the overall performance of the disabled person, and that was the revised definition of "substantial handicap to employment":

"Substantial handicap to employment" means that a physical or mental disability (in the light of attendant medical, psychological, vocational, educational, cultural, social, or environmental factors) impedes an individual's occupational performance, by preventing his obtaining, retaining, or preparing for a gainful occupation consistent with his capacities or aptitudes." Section 401.1(x).

Previously, it had been required that there be demonstrated a direct causal relationship between the disability and the substantial handicap to employment. The new provision recognized that limited educational, medical, social, or other factors provided fewer resources for coping with the effect of a disabling condition without the disabling condition directly affecting the occupational performance.

Some Definitions of Behavior Disorder

The terminology of the revised definition does in itself lead to erroneous interpretation. The standard meaning assigned to the term "behavior disorder" by the psychiatric profession relates to a disorder of childhood and adolescence:

"Behavior Disorder-- . . . refers to a group of psychiatric disorders in children or adolescents which are not secondary to

somatic diseases or defects or to convulsive disorders and which are not part of a well defined psychosis or psychoneurosis. The primary behavior disorders are considered to be reactions to an unfavorable environment; they appear as problems of personality development; as persisting undesirable traits or unfavorable habits . . .; as delinquency or conduct disorders . . .; as certain neurotic traits . . .; and as problems of school and general educational or vocational difficulties. In the past, children with such disorders were referred to as 'problem children.'" (Hinze and Campbell, 1960.)

The rehabilitation program does not concern itself exclusively with the problems of children and adolescence (although the 1965 Amendments rule out any age requirement, in and of itself, as limiting eligibility); hence, relating "behavioral disorders," as used in the Regulations governing the rehabilitation program to "behavior disorder," as understood by the psychiatric profession, proved to be very difficult.

That "behavioral disorder" was a disability that is distinct from any demographic variable was made clear by the Rehabilitation Service Series Number 67-18, issued September 28, 1966, in which the distinction was made between behavioral disorder, a disability, and public offender, a sociological characterization:

"The public offender, as a public offender, therefore may not be considered categorically eligible for rehabilitation services, but must have his eligibility established on the basis of an individual evaluation as in the case of any applicant for services . . . Although studies have shown that public offender populations are characterized by a relatively high proportion of mental retardation, emotional disturbance, and physical disability, there is clearly a sizable group of public offenders whose disability is essentially behavioral . . . Where behavioral disorders are involved, a psychiatric or psychological evaluation must be obtained in accordance with Section 401.32(e) (2) (of the Regulations)."

Further clarification of what was meant by behavioral disorders was made by the issuance of Chapter 16, Part 1, Eligibility, of the Vocational Rehabilitation Manual.

"Behavioral disorders are included in the Regulations under 'physical or mental disability.' Behavioral disorders may be, but are not necessarily, medically diagnosable conditions. Their presence will be established by either a psychiatric or psychological evaluation, whichever is appropriate."

"A behavioral disorder is present when, through an evaluation, it is determined that an individual's behavior significantly deviates from what is considered normal or that his ability to carry on normal relationships with family and community is significantly impaired."

"An individual with a behavioral disorder exhibits abnormal behavior which persists over a period of time and manifests itself in various settings such as in school, on the job, before the courts, and in the family. . . . such incidents and behavior as family quarrels, arrests, truancy, idiosyncracies, or mannerisms do not, in themselves, constitute a behavioral disorder but may be suggestive of the existence of such a disability.

"Factors such as cultural and social deprivation, chronic poverty, public offense, illiteracy and educational deficit, and long-term unemployment do not, in themselves, constitute behavioral disorders, but may contribute to the formation of a behavioral disorder."

The issuances from the VRA and later the RSA Central Office were over a period of time. During this time there persisted the widespread belief that behavioral disorders and disadvantaged were synonymous for purposes of eligibility for vocational rehabilitation services.

The Council of State Administrators of Vocational Rehabilitation, an associated organization of the National Rehabilitation Association, quickly embraced the revised definition of physical or mental disability, and recognized it as a mandate to serve larger numbers of disabled persons in line with the manifest needs of the times. In a "Statement of Mission and Goals," the CSAVR discussed the new provisions in a statement that has frequently been cited:

"The current definition of disability in the regulations governing the administration of the Vocational Rehabilitation Act results in millions of handicapped people who are 'eligible' for vocational rehabilitation services. In addition to individuals whose disabilities are the result of medically definable physical or mental impairments (the traditional sources of agency clientele), there are added millions whose disabilities consist of behavioral disorders characterized by deviant social behavior or impaired ability to carry out normal relationships with family and community, which may result from vocational, educational, cultural, social, environmental, or other factors. Eligible for vocational rehabilitation services under such a definition may include the public offender, the alcoholic, the drug addict, and the socially and culturally deprived, provided these people are truly 'handicapped'

in finding and holding suitable employment. In considering the relationship of disability to handicap, one considers all of the factors--environmental, educational, and social--which will impede a person's performance and intensify the vocational handicap."

"This broader definition of disability is intended to free State vocational rehabilitation agencies from the restrictions imposed by previous definitions of disability and its relation to handicap, and to enable them to use their services and skills freely to serve handicapped people who obviously can profit from vocational rehabilitation services, but who might have been excluded from such services because they did not appear to be 'disabled' under traditional interpretations of the meaning of disability."

This excerpt from the "Statement of Mission and Goals" is forward looking and reflects a willingness to accept new challenges and new directions for the program. Unfortunately, it is not a totally accurate reflection of legal realities. Alcoholism and drug addiction are medically definable disabilities and have been since the 1943 Amendments to the VR Act, and should not be categorized as "behavioral disorders" for rehabilitation purposes. Further, a vocational problem does not define the disability, though it may be an indication that a disability is present.

The report of the National Citizens Advisory Committee for Vocational Rehabilitation, though showing some inconsistency in different sections, recognized that behavioral disorder was a category of disability, and stated:

"Vocational rehabilitation, with its history of service to handicapped people, needs a law and implementing regulations which are straightforward in their intent to serve all those who are vocationally handicapped, regardless of the cause."

EVALUATIONS IN CASES OF BEHAVIORAL DISORDERS

The Regulations issued following the 1965 Amendments provided that in all cases of behavioral disorders, a psychiatric or psychological evaluation, as appropriate, would be obtained. Questions arose regarding (a) the nature or content of the evaluation; (b) the qualifications of the individual performing the evaluation; and (c) determining whether a psychological or psychiatric evaluation was appropriate.

The Regulations (October, 1969) read:

"(e) The State plan shall provide that (1) in all cases of mental

retardation a psychological evaluation will be obtained which will include a valid test of intelligence and an assessment of social functioning and educational progress and achievement; (2) in all cases of behavioral disorders a psychiatric or psychological examination will be obtained, as appropriate; and (3) in all cases of blindness an adequate hearing evaluation will be obtained." (401.32e)

The Regulations (October, 1969) further read:

"The State plan shall provide that the State agency will establish and maintain standards for the various types of facilities and professional personnel utilized in providing services to handicapped individuals, and shall describe the general content of such standards and the bases on which they were developed. The State plan shall also set forth the methods to be employed for maintaining such standards in accessible form for agency personnel." (401.42)

There is, however, no nationally uniform set of standards to qualify an individual as a psychologist, though licensure or certification laws are becoming more prevalent. In any event, the Regulations are clear in reserving for the State agency the authority for setting standards for agency staff and for consultants utilized by the agency.

Determination of the appropriate professional to evaluate a behavioral disorder is also a prerogative of the State agency within the requirement that psychiatric evaluation is required in all cases of mental illness. Hence, as outlined in Manual Chapter 16, if mental illness is suspected, the case evaluation might be more expeditiously handled by ordering a psychiatric evaluation first.

Serving the Disadvantaged - Some History

The question of whether "behavioral disorder" was in effect a synonym for "disadvantaged" was raised in the Senate Hearing on H. R. 16819, conducted prior to the 1968 Amendments to the VR Act. In response to questions submitted by Senator Javits of New York, clarifications were made which borrowed heavily from the Regulations and Manual Chapter 16-1. Excerpts of the questions asked and the answers prepared in reply follow:

Q. Sec. 13 of H. R. 16819 provides a new program of grants to the States for evaluation and work adjustment services to disadvantaged persons, ...

(a) It has been indicated that the definition of handicapped has been broadened administratively by your agency to

include impairment due to "vocational, cultural, social, environmental, or other factors." Could you furnish the Subcommittee with the text and details of this?

(b) Why is this new language suggested by Sec. 13 necessary?

.....

A. Text of details on "behavioral disorder:" The definition of "physical or mental disability" was clarified in the Regulations following the 1965 VR Amendments as follows (Federal Register, Vol. 31, No. 9, Title 45--Public Welfare, Chapter IV, Part 401, Subpart A, Section 401.0(o)):

(The text then copied the specified Section of the Regulation.)

The policy and definitions with respect to behavioral disorders were further clarified in the Vocational Rehabilitation Manual, Chapter 16, Section 1, as follows (Italic is added to point to the reasons that new language is needed in order to allow evaluation services to disadvantaged persons):

Behavioral disorders are included in the Regulations under "Physical or mental disability." Behavioral disorders may be, but are not necessarily medically diagnosable conditions. Their presence will be established by either a psychiatric or psychological evaluation, whichever is appropriate.

(The text then copies extensively from Chapter 16, Section 1.)

Factors such as cultural and social deprivation, chronic poverty, public offense, illiteracy and educational deficit, and long-term unemployment do not, in themselves, constitute behavioral disorders, but may contribute to the formation of behavioral disorder.

In the preparation of the language of H.R. 16819, recognition was given to the legal limits of the definition of disability. From this followed the Amendment to the VR Act that authorizes provision of Work Evaluation and Work Adjustment services to the "disadvantaged," now incorporated as Section 15 of the VR Act. The Section 15 program is for limited services for non-disabled persons. If any individual referred for Section 15 services is found to have a disability, he should then be referred to the regular Section 2 program.

For purposes of Section 15, "disadvantaged" is defined as:

"As used in this section, the terms 'disadvantaged individuals' means (i) handicapped individual as defined in section 11(b) of this Act, (ii) individuals disadvantaged by reason of their youth or advanced age, low educational attainments, ethnic or cultural factors, prison or delinquency records, or other conditions which constitute a barrier to employment, and (iii) other members of their families when the provision of vocational rehabilitation services to family members is necessary for the rehabilitation of an individual described in clause (i) or (ii)." (P.L. 90-391, July 7, 1968)

The Section 15 program provides only two services for the non-disabled disadvantaged: work evaluation and work adjustment. It is seen as a community service operated by the State rehabilitation agency under a separate State plan, providing individualized evaluation and training in job attitudes and potential skills prior to the individual enrolling into the vocational training and placement activities which have been established to serve the non-disabled.

If a disadvantaged person referred for work evaluation and work adjustment service is found to have a physical or mental disability, he should then, of course, be referred to the State VR agency for additional services.

The main VR thrust in serving the non-disabled disadvantaged in the past has been in making VR services more available to the disabled among the disadvantaged. These efforts include research and demonstration projects, especially the 26 demonstration projects for rehabilitation of public assistance recipients, expansion projects, in which VR units are established in neighborhood service centers, efforts of the State agencies to establish offices in areas of cities in which the exhibited need is greatest, and recently, an agreement with the Social Security Administration for the placement of VR personnel in certain Social Security offices.

CHAPTER III

REPORT OF SURVEY

Rationale for Survey

In order to adequately describe the present "state of the art" insofar as the rehabilitation of those individuals with behavioral disorders is concerned, it was felt that an effort to obtain current data from those serving in rehabilitation was imperative. In an effort to obtain data with a high degree of validity from the respondents (all State agencies), the following excerpts from the Federal VR Manual (Chapter 16-1, July 26, 1967) served as an introduction:

" A behavioral disorder is present when, through an evaluation, it is determined that an individual's behavior significantly deviates from what is considered normal, or that his ability to carry on normal relationships with family and community is significantly impaired."

"An individual with a behavioral disorder exhibits abnormal behavior which persists over a period of time and manifests itself in various setting such as in school, on the job, before the courts, and in the family. Such incidents and behavior as family quarrels, arrests, truancy, idiosyncracies, or mannerisms do not, in themselves, constitute a behavioral disorder but may be suggestive of the existence of such a disability."

The survey was sent to all State vocational rehabilitation agencies including the agencies for the blind and/or visually impaired. The difficulty in responding on the part of the agencies for the blind and/or visually impaired was compounded by the fact that the primary disability served by such agencies is visual in nature and that statistics on secondary disabilities such as behavioral disorders are not gathered in any organized manner.

If one may borrow a standard cliché, the data collected is intended to "Tell It Like It Is." The survey is divided into six parts: General Information, Programs Serving Individuals with Behavioral Disorders, Delivery Systems, Resources, Needs and Barriers.

Survey Overview

The survey questionnaire (Appendix A) was mailed to 91 State agencies of vocational rehabilitation. Responses were received from 59 agencies (65% of total); including 38 of the 54 "general" agencies (70%), and 21 of the 38 agencies for the blind and/or visually handicapped (57%). All geographical areas of the United States are represented by the respondents; however, a few of the larger agencies did not return the questionnaire. Those agencies responding are listed below:

GENERAL AGENCIES

Alabama	Kansas	Oregon
Alaska	Kentucky	Puerto Rico
California	Louisiana	Rhode Island
Colorado	Maine	South Carolina
Connecticut	Maryland	South Dakota
Delaware	Minnesota	Tennessee
District of Columbia	Missouri	Texas
Florida	Nebraska	Utah
Georgia	New Hampshire	Vermont
Guam	North Carolina	Washington
Idaho	North Dakota	West Virginia
Illinois	Ohio	Wisconsin
		Wyoming

AGENCIES FOR BLIND AND/OR
VISUALLY HANDICAPPED

Arizona	Missouri	Oregon
Delaware	Montana	Rhode Island
Florida	Nebraska	Tennessee
Kansas	New Jersey	Texas
Louisiana	New Mexico	Vermont
Maine	New York	Virginia
Massachusetts	North Carolina	Wisconsin

PART I

Part I of the questionnaire was designed to gather information regarding guidelines directed to staff for providing service to individuals

whose primary disability was behavioral disorder; to describe the approach vocational rehabilitation agencies were following in obtaining evaluations; to gather data on the number of clients with behavioral disorders who were rehabilitated.

The respondents were asked if they gave their staff any guidelines for providing services to individuals whose primary disability was behavioral disorder. They were also asked to attach a copy of such guidelines, if any, to their responses. Sixteen agencies reported providing guidelines to staff, 38 reported that guidelines were not provided to staff, and 5 agencies did not respond to this item. Of those agencies reporting that they provided guidelines to staff, the most usual approach was in the form of a Manual of Procedure or Counselor's Manual in which definitions were quoted from the Federal Register and the Vocational Rehabilitation Regulations.

A report received from one general agency provided the most complete information on this topic in a memorandum on in-service training materials. This material pointed out that a referral of an individual with a behavioral disorder could come from any source but anticipated a high incidence of referrals from O. E. O., Division of Welfare, Manpower Development and Training Act, Model Cities, the Division of Youth Service and Division of Corrections. The material also recognized the uniqueness of this client and the necessity of the counselor to develop new techniques and methodology of evaluation and service.

In the second sub-area of General Information, the respondents were requested to describe their method of obtaining psychological and psychiatric evaluations for these individuals. The purchase of evaluations from private practitioners was reported by 46 agencies, 9 agencies reported the purchase from mental health clinics, 8 agencies reported obtaining psychological and psychiatric examination through cooperative programs, 8 agencies reported obtaining such evaluations through public institutions (hospitals, prisons, etc.), 6 agencies reported providing psychological evaluations through agency consultants, 2 agencies reported obtaining evaluations through psychiatric consultants, 2 agencies reported providing the service through counselor determinations, and 1 agency reported the purchase of such evaluations through a rehabilitation center.

In the third part of this category agencies were requested to report the number of clients with behavioral disorders who were served in FY 67-68, and the increase or decrease over FY 66-67. Twenty-eight agencies failed to respond to this item. The data provided by the 31 agencies responding is given below. The percentage of increase over FY 66-67 ranged from 0 to greater than 100.

<u>CLIENTS SERVED</u>	<u>AGENCIES</u>	<u>CLIENTS SERVED</u>	<u>AGENCIES</u>
0	7	351-400	1
1-50	4	401-450	0
51-100	3	451-500	3
101-150	1	501-1000	2
151-200	1	1001-2000	0
201-250	0	2001-3000	3
251-300	1	3001-4000	2
301-350	0	4001-5000	2
		Over 5000	1

In the last section of this category the agencies were requested to provide data on the number of clients with behavioral disorders who were rehabilitated in FY 67-68, and the percentage of increase or decrease over FY 66-67. Twenty-five agencies did not respond to this item. Several respondents indicated difficulty in providing this information as the behavioral disorder category is not treated as a discrete disability code on the R-300. The percentage of increase over FY 66-67 ranged from 0 to greater than 100. The description of the number of behavior disordered clients rehabilitated in FY 67-68 is provided below:

<u>CLIENTS REHABILITATED</u>	<u>AGENCIES</u>	<u>CLIENTS REHABILITATED</u>	<u>AGENCIES</u>
0	7	301-350	1
1-50	5	351-400	1
51-100	5	401-500	1
101-200	4	500-1000	7
201-250	0	1001-2000	1
251-300	0		

PART II

Part II of the questionnaire was designed to provide information on the various programs utilized by State agencies in serving individuals with behavioral disorders. Many of the programs listed were unavailable to a large number of States. The responses of the agencies to this item are presented below:

Instructions--Please indicate, by checking under the block YES, or the block NO, if your agency is serving individuals with behavioral disorders in each of the following situations:

<u>SITUATION</u>	<u>YES</u>	<u>NO</u>
1. General VR caseload	43	11
2. Special VR caseload	40	13
3. Neighborhood Services Programs	17	36
4. Concentrated Employment Projects	17	37
5. Cooperative Manpower Projects	13	40
6. Third-party agreements	35	18
7. Research and Demonstration Projects	16	37
8. Expansion Grant Projects	23	30
9. Innovation Grant Projects	18	35
10. Special Manpower Development & Training Act Project	20	33
11. New Careers	9	44
12. Operation Mainstream	30	47
13. Neighborhood Youth Corps	19	34
14. Work Incentive	20	33
15. Job Corps	15	38
16. On-the-job training (State Employment Service)	22	30
17. Opportunity Industries Center	9	44
18. Migrant Opportunity Services	4	49
19. Model Cities Projects	16	37
20. Human Resources Development Concept (State Empl. Ser.)	12	41
21. Labor Mobility Projects (U.S. Dept. of Labor)	4	49
22. Labor Education Advancement Program (U.S. Dept. of Labor)	2	51
23. Other Specific Projects	8	45

One of the most interesting special projects can best be described as a "spin off" of the Neighborhood Service Program. This concept has been called the Mayor's Station. The Mayor's Station is an inner-city neighborhood station with staff representing various helping agencies such as Employment Service, Probation and Parole, Vocational Rehabilitation, Legal Aid, and others. The emphasis in these stations is in providing services without delay, making maximum utilization of the neighborhood resources so that the need for going out of the neighborhood for services is minimized.

PART III

Part III of the questionnaire was designed to elicit information as to the various delivery systems in use by State agencies in providing services to clients with behavioral disorders. Clients with behavioral disorders

were assigned to counselors with general caseload in the traditional VR office in 46 agencies. Thirty-eight agencies reported that clients with behavioral disorders were assigned to counselors with a "special" caseload in the traditional VR office. Nineteen agencies reported utilizing a decentralized branch, or store front office, in close proximity to the residence of the client. Sixteen agencies reported utilizing multi-service or neighborhood service centers. Thirteen agencies reported serving clients with behavioral disorders through multi-disciplinary teams in VR offices. Three agencies reported the use of mobile teams of specialists and/or equipment to provide appropriate services in rural areas to those individuals with behavioral disorders. Twelve agencies reported the use of individuals indigenous to specific disability groups (for example, using recovered alcoholics to work with alcoholics, rehabilitated convicts to work with other public offenders, etc.). Thirteen agencies reported that services were provided through unique delivery systems not described above. Please refer to Appendix B for agency preference regarding delivery system to be used in the provision of services to clients with behavioral disorders.

PART IV

Part IV was designed to provide information regarding resources available to serve individuals with behavioral disorders. Such resources include staff, institutions, consultants, programs and training, including training needs. Mental health centers were reported to be available to serve clients with behavioral disorders in 17 agencies. Fifteen agencies reported programs in correctional institutions, juvenile courts, and probation and parole office as providing services. Thirteen agencies reported psychiatrists and/or psychologists in private practice as available resources. Twelve agencies reported State mental hospitals available as resources. Eight agencies reported private or public rehabilitation centers as resources for service to clients with behavioral disorders. Eight agencies indicated that school psychologists, pupil service divisions, special education sections and vocational education divisions of public schools as providing services to this clientele. Six agencies reported outreach, community neighborhood centers, youth opportunity centers and youth corps centers as an available resource. Six agencies reported community hospitals as a resource for the provision of services. Six agencies reported the Employment Service, including Manpower Development programs, as resources available. Four agencies reported the availability of transitional residences or halfway houses. Four agencies reported that workshops were available within their State for services to this group. Psychiatric clinics were reported as a resource in three agencies.

Juvenile department group housing was reported as an available resource by two agencies. Many agencies indicated that all of the services and resources which were available to the client not having a behavioral disorder were also available to service individuals with behavioral disorders.

For a list of the training in which agency staff was involved in FY 67-68 in the area of behavioral disorders, please refer to Appendix C. Training materials leading to an understanding of the nature of a behavioral disorder, the assessment of a behavioral disorder, and knowledge as to how one copes with a behavioral disorder were the choice content of training material. Many academic courses in human assessment, abnormal psychology and psychopathology were listed as providing assistance in meeting this training need. The response of one general agency as to the basic kind of content material in training that needs to be given to the counselor in order that he could do his job in working with the behavioral disordered exemplifies the responses. Attitudes toward people are more important than academic skills--training should center around human understanding and knowledge of the environment that helped create the behavioral problem.

Most of the agencies responding indicated that they felt administrators and supervisory personnel should have the same type of training as counselors in order to serve individuals with behavioral disorders.

PARTS V AND VI

Parts V and VI were designed to provide identification of the most urgent needs and the greatest barriers, other than staff and money, of the State agencies in serving individuals with behavioral disorders. The difficulties which the respondents experienced in differentiating between needs and barriers is quite evident upon review of the major categories. In most instances the lack of a resource was described as a barrier which many of the respondents felt shows an urgent need. For example, the following categories are duplicated on both lists:

- Training Resources
- Housing
- Unsatisfactory Educational Services
- Facilities
- Pressure of Present Caseload
- Interagency Cooperation
- Research
- Professional Psychologists and Psychiatrists

Summary

Emerging patterns of service to rehabilitate individuals with behavioral disorders indicate a diversity of programs taking place on a broad base. Many different approaches are being tried with varying degrees of success. There is a lack of clarity as to whom should properly be identified as having a behavioral disorder. Should the term encompass public offenders, alcohol and drug abusers, as well as others with character disorders usually described by a psychiatrist? Should a group of disability codes be recognized as behavioral disorders, or could one definition be developed with a discrete disability code?

Perhaps the time is ripe for an objective evaluation of the results of some of the staffing patterns in use and some of the delivery systems in vogue for serving this population. Until such findings are made and distributed widely, many agencies will continue to "move with dynamic caution" as one administrator so aptly described his position.

The Committee would like to take this opportunity to express its appreciation for the depth of understanding exhibited and the cooperative attitude expressed by the respondents.

CHAPTER IV

ISSUES IN COUNSELING APPROACHES

This chapter will focus specifically on rehabilitation counseling practices with the behaviorally disordered client. We will begin by reviewing issues in traditional rehabilitation counseling strategies and specific sources of dissatisfaction with traditional approaches, proceed to an analysis of current rehabilitation counseling practices and conclude with an analysis of new and innovative counseling models to be considered for use in successful rehabilitation of the behaviorally disordered client.

Issues in counseling approaches: Behavioral scientists and practitioners have begun to take a hard look at traditional counseling delivery systems as the only or best approach for all rehabilitation clients. Traditional counseling, typically, is composed of: A "fifty minute" hour, the professional rehabilitation counselor, a client, and a professional-type office. "Behind the closed door," the rehabilitation counselor uses verbal interchanges between himself and his client to alter client behavior "beyond the closed door." Most practicing rehabilitation counselors cannot operate precisely in this manner, but it is a model to which the professional counselor had tended to aspire. The sources of the disenchantment with this traditional "fifty minute" hour approach are quite diverse. However, the fundamental basis is the lack of satisfactory evidence for its effectiveness. That is to say, the traditional counseling model has not proven to be effective with a variety of rehabilitation clients. In addition, it tends to be inefficient, time consuming, and works least well with those who need it most.

To place the issues in perspective, the traditional counseling approach has evolved, primarily, from the experiences of counselors and therapists with upper and middle-class neurotics and upper and middle-class college students. It has not developed out of experiences of the typical rehabilitation agency. Thus, counseling so conceived is a middle or upper-class phenomenon. Clients who appear to profit from it are those who show a willingness to communicate problems and feelings to others, have high needs for achievement, higher social class background, more formal education, higher measured intelligence, and greater anxiety and self-dissatisfaction. In general then, the best prospect for success with the traditional counseling approach may be characterized as not particularly disturbed, well motivated, well educated, and with good personal resources. A review of the list of "good" clients leads one to the

conclusion that such clients would be excellent prospects for success in almost anything. Some psychologists have concluded that it is more the nature of the client population than the approach that is responsible for successful outcomes utilizing traditional counseling approaches.

To summarize, then, the traditional counseling model evolved out of experiences with middle-class neurotics and college students. It appears to be based on a doctor-patient relationship and presupposes the type of client rehabilitation agencies rarely see, i.e., one who is verbal, self-insightful and highly motivated toward increased self understanding.

In the past, the large numbers of clients unable to profit from the traditional approach were classified as "unsuitable candidates" for counseling or for rehabilitation in general. The numbers of clients now classified as such include: the delinquent, the multi-problem family, the poor, those with low intelligence, the non-verbal, the severely disturbed, and those with poor impulse control. In short, it seems to include a substantial portion of clients needing assistance from vocational rehabilitation in improving their circumstances.

Other sources of dissatisfaction with the current approach are to be found in critiques of the medical model (although they may not verbalize their approach in these terms). Simply stated, a set of symptoms are identified, a differential diagnosis made, treatment prescribed, and the cure follows. Such an approach presupposes either a defective organic structure or maladaptive intrapsychic equipment. Both approaches posit treatment, resulting in a healthy, well-functioning organism. Szasz (1960, 1969), a psychiatrist, and Albee (1966, 1968), a psychologist, have been outspoken opponents of the medical model. It is their thesis that mental illness, as such, does not exist, and that what is called mental illness is qualitatively different from any other sickness. Albee finds little use for the metaphorical mental apparatus of the psychoanalytic school. Szasz insists that much of what falls under the rubric "mental illness" is no less than sophisticated name-calling.

Diagnostics, the sine qua non of those operating within the parameters of the medical model, has come under increasing attack. There is evidence now available to suggest that much of our elaborate diagnostic evaluations (those predicting general personality functioning) have little value for vocational rehabilitation. The traditional diagnostic instruments tend to have low predictive validity for rehabilitation clients. This attack is leveled against the fancy diagnostics. It should not be construed as a criticism of valid psychological tests and inventories: e.g., school tests, tests of general intelligence, interest inventories, objective personality inventories, etc. The general prevocational evaluations are still considered to be useful.

The so-called counseling process has also come under attack. Its most severe critics contend that its existence has not as yet been demonstrated. Its more charitable critics contend that sole attention to the fifty-minute hour process dooms a professional area utilizing this approach (including rehabilitation counseling) to a short life. As indicated, only a minority of clients in need of behavioral change are able to profit from the traditional fifty-minute hour approach. The essence of this particular criticism would be found in the contention that we need to demonstrate successful rehabilitation outcomes before we can conduct molecular examination of the so-called counseling process.

Manpower demands have also been a source of dissatisfaction with the current counseling approach. Critics insist that our present utilization of professional manpower in rehabilitation and other helping professions but scratches the surface of those truly in need of help. Thus, it is asserted that the majority of time spent by professional rehabilitation counselors, therapists, psychiatrists, etc., is very probably spent with those who need help least.

Current Practices with the Behavioral Disorder Client

The incidence of delinquency, promiscuity, alcoholism, and many other social problems related to behavioral disorders tends to increase as we move into the lower socio-economic stratum (or the culturally different, now in vogue as a euphemism for black or poor).

One of the rehabilitation client groups that appear to fit least well with the traditional model is precisely this poor person with a grossly disordered life style who is classified in the "behavioral disorder" category.

Thus the poor, both black and white, tend to be over-represented in the behavioral disorder category. Their learning contexts have not led them to develop an orientation toward the future, to be planful, to be verbal, to be self-knowledgeable. Rather, experiences have led them to conclude that they have little control over their own fate. While the middle-class person tends to attribute causality of his life to inner forces, one who is poor tends to attribute causality to external and arbitrary forces and pressures.

For these reasons, the poor have been found to be generally unsuitable as candidates for traditional counseling. Their developmental history has been sufficiently different from middle-class clients; their goals, aspirations, expectations, etc., vary greatly. Thus, the poor tend to make little use of traditional rehabilitation counseling. They will not wait for services; they will not seek out services.

Despite the low utilization of rehabilitation counseling services, the poor as a group, show high need for assistance in changing their circumstances. As indicated, they are over-represented in the behavioral disorder category. And, there is greater incidence of markedly disordered lives, alcoholism, promiscuity, mental illness, etc. (e.g., Hollingshead and Redlich, 1958).

Behavioral Disorder as a Disability Category

Rehabilitation has used an efficient procedure for determination of the eligibility of persons for rehabilitation services. To review the procedure briefly, in order to be deemed eligible for rehabilitation services it was necessary that a person has a medically demonstrable disability; that this disability constitutes a substantial handicap to employment; and that there exists a reasonable expectation that rehabilitation services will aid in the eventual attainment by the person of suitable employment. This formula was developed from early work with the physically disabled. It worked well with this population. To illustrate, it is relatively clearcut to determine the physical limitations accompanying a B/K amputation and not too difficult for the counselor to relate this to employment possibilities. However, in the instance of the mentally retarded and mentally ill, the formula became more difficult to apply. And when we apply it to people who have behavioral disorders, it would not apply.

In the behavioral disorder disability category traditional eligibility determination procedures operate in a manner referred to by scientists as a "convenient fiction," i.e., in the scientific sense of "constructs," "idealizations," "as if," notions. That is, we can diagnose behavioral disorders, determine that such disorders constitute a substantial handicap to employment and judge that rehabilitation can be of substantial assistance to such persons. However, the concept of behavioral disorder as it applies to the poor is saturated with socio-cultural components. In that sense, the traditional concept of medical disability as it applies to the poor classified as behaviorally disordered is a "convenient fiction" in the very same sense that we know the "purely economic man" to be a convenient fiction. It is unlikely that "behavioral disorder" constitutes a pure psychiatric category when applied to the poor. The debate as to the genuineness of "mental illness" as a medical disability is quite legitimate; but, poor people with grossly disordered life styles have demonstrable deficits in specific employment skills, attitudes, abilities, and opportunities. And these deficits constitute a substantial handicap to employment. The real merit for classifying such deficits as medical disabilities is only as a conceptual shorthand, a linguistic tool from which to develop appropriate rehabilitation strategies.

The following statements appear to be applicable to the behavioral disorder group (Curric Dev Com, 1968).

1. A history of continued failure and negative reinforcement as a result of temporary or deadened employment and extended unemployment. Lack of vocational skills.
2. Frequent low self-esteem, alienation and easy discouragement.
3. Multiple and complex barriers to employability including inadequate or inferior education (lack of basic skills in reading, math, etc.), chronic health problems, police records, discriminatory hiring practices on the part of employers, lack of transportation to jobs, and for women, often a lack of adequate child-care facilities.
4. Presence of immediate financial crisis.
5. Resistance to and the inappropriateness of many paper and pencil type standardized assessment devices.
6. Wide differences in values and frequent confusion in value systems. Work attitudes and motivation may be very different from those of the dominant society.
7. Low frustration tolerance for perserverance in lengthy developmental programs.
8. Most clients from economically disadvantaged backgrounds are members of minority groups. Families are likely to be large. The proportion of households headed by women is substantial.
9. Resistance to change.
10. Reluctance to take risks.

This definition contains three important dimensions: the essences, causes, and symptoms of cultural deprivation. The causes of this deprivation are familial, educational, psychological, economic, and social. resulting in symptoms of frustration, mistrust, dependency and alienation.

Current Pracitces in Rehabilitation Counseling

We have indicated that the traditional model of counseling and of service delivery does not work well with clients who have failed to develop

middle-class views of what it is to be a client. The mental health delivery system reflects such problems. Typically, the poor person who receives mental health services does not receive the "fifty minute" hour approach; rather, he is likely to receive the "pills and needles" approach. Precisely because this is what he understands and expects. There is evidence to suggest that the poor view disability and illness, in general, differently from their middle-class counterparts. For instance, it is more socially acceptable for a poor person to remove himself from the labor market due to the "low back syndrome."

While the speech system of the poor is quite appropriate for his natural environment, it is inappropriate for the counseling relationship. It does not fit the demands of the traditional rehabilitation counseling relationship. Typically, the client (or rehabilitation counselor) finds the relationship unrewarding and terminates it.

Despite accumulated evidence that the behaviorally disordered poor do not profit from traditional techniques, there remains a tendency for many vocational rehabilitation agencies to continue to look upon such persons as unmotivated middle-class clients. Thus, the behaviorally disordered poor are often viewed as recalcitrant and uncooperative, or as being a product of a hostile, unyielding environment, or as "damaged" or as stupid. Quite naturally these notions lead the rehabilitation counselor to view the behaviorally disordered poor as hopeless rehabilitation cases.

New Delivery Systems

A number of innovative programs have been initiated by governmental agencies; e.g. H.E.W., Department of Labor, and O.E.O. (These programs will be covered in the chapter on "Current Practices in Rehabilitation Delivery Systems.") Such programs have been initiated to increase the probability of success in working with the poor, in general, including those who are behaviorally disordered. These programs have met with varying degrees of success. But there are several commonalities in the innovative approaches from which we may draw inferences as to more effective ways of working with this population.

NEW MODELS

1. Experience with behaviorally disordered poor has necessitated reformulation of the disease paradigm into problems of learning. Experience has shown that although it may be enjoyable to probe

for deep, underlying pathology, this approach rarely leads to successful outcomes. Rather, success occurs when we view specific behavior as either adaptive or maladaptive. We can identify deficits in adaptive behavior and then attempt to teach the client appropriate behaviors.

2. One-to-one counseling has been found not to be enough. Warmth, understanding, genuine concern for a client may be necessary but not sufficient conditions for success with the behaviorally disordered client. Of course, it is important that the counselor communicate to the behaviorally disordered client that he cares and is concerned. But it has been found necessary to expand this to other techniques necessary to effect rehabilitation (Gellman, 1967). The Youth Opportunity Centers, as well as the HRD experimental and demonstration projects conducted in Chicago, Houston, St. Louis, Los Angeles, and Rochester, New York by the USES and a wide variety of innovation, expansion and R & D projects in rehabilitation, demonstrate that new techniques must be used with the poor. Use of professional personnel was not enough. In these programs, personal contact, often through the use of trained indigenous workers in the homes, hang-outs, etc., was necessary to build the bridge between the employment service and the chronically unemployed.
3. It was necessary that the rehabilitation plan be clearly related to work. The successful projects emphasize the immediate availability of services such as trade schools, beautician schools, etc., to the client. The traditional psychological assessment, school placement and follow-up tends not to work with this population. The client needs to be given responsibility for his own success in a school program. If he is dissatisfied with his learning program, efforts should be made to make program adjustments to fit the client's needs. Generally, he will not tolerate long delays and formalized procedures, nor can he be coerced into a training program.
4. There is a clear indication that an anti-psychiatric orientation works best with the behaviorally disordered poor. That is to say, the rehabilitation counselor who views his client from the perspective of the middle-class and misinterprets anger, withdrawal, and suspicion, as paranoia is unlikely to be successful. Ghetto residents are tired of being used by good-hearted middle-class social welfare professionals.
5. What is needed seems to be sincere, open communication--less formal doctor-patient relationships, and more human interaction.

Office hours need to be modified to fit the needs of the behaviorally disordered poor. The rehabilitation counselor may often need to be available after 5 p.m. or on weekends, if necessary, for his client.

6. Paternalism--kindly condescension--is inappropriate for the behavioral disordered poor. In the instance of the ghetto resident, this reaction on the counselor's part is likely to be disastrous. He will insist on the counselor telling it how it is. It has been found necessary to be active in the community not as a leader, but as a participant in community neighborhood council, coordinating councils, etc.
7. Since there are a multiplicity of agencies dealing with this population, it becomes a necessity to learn effective means of cooperation with these agencies. Successful projects have found ways of giving tangible credit to other agencies working with their clients by correctly assessing the reward system of other agencies working with a given client.
8. Gross (1969), reporting on a survey of Youth Opportunity Centers, suggests that traditional counseling techniques are not sufficient for the disadvantaged and suggests self-help "as represented, for instance, by the Opportunities Industrialization Center." He asks the rhetorical question: "What will counselors have to offer these self-help movements? Advice on setting up counseling and job-training and job-finding facilities, and when it is asked, direct assistance." Gross stresses that although the traditional approach works for some, we must make it possible "for someone to come--simply as a man--for help and direction" (p. 409). Gross believes if seeking such help makes a person feel any less than a man (the major danger he sees in traditional programs), then the person needs to turn to a place of his own.
9. Walker (1968) suggests that a basic error made by most rehabilitation counselors is that of treating behaviorally disordered poor as if they were middle-class neurotics. He posits a client assessment model for the hard-core unemployed developed to answer the question: "What behaviors must be presented in an interview in order for an individual to be hired?" Walker's assessment model consists of the five following areas: (1) ability to explain skills, (2) ability to answer problem questions, (3) appropriate appearance and mannerisms, (4) enthusiasm for work, (5) fine points of the job interview. Walker insists that this assessment model far surpasses the traditional "psychological

model" in effectiveness. It does so insofar as (1) it is based upon operational behaviors which can be understood and agreed upon by independent observers; (2) the client himself knows the standard or goal, knows exactly what changes are expected, and what he must do to meet the standard of performance; (3) clients understand the vocabulary used in the model. The model makes use of specific non-psychological terms to describe behaviors that help the client to understand the information provided him and that encourage him to become involved in trying to change his own behavior.

SUPPORT PERSONNEL IN VOCATIONAL REHABILITATION

Manpower shortages in the helping professions have resulted in the development of a new group of personnel positions "which are variously referred to as auxiliary, ancillary, technical, non-professional, paraprofessional, subprofessional, or support personnel" (I.R.S. Training Guide, 1969, p. 7). Support personnel models are being utilized in a variety of rehabilitation settings. Such models have made better use of professionally trained counselors without diminishing quality of services. In fact, there is some evidence to suggest that support personnel models provide for a more effective delivery of services (Trufax, 1967). Rehabilitation programs, ES programs, OEO programs, welfare programs, parole programs, and secondary education programs are now using support personnel. "Indigenous aides" have been used with black and Mexican-American populations; long-term--welfare recipients; those "dis-employed" due to multiple social, psychological, and educational problems, and the rural poor.

Increased emphasis needs to be placed on course content and opportunities for development of skills and supervision, administration, and consultation in order to prepare rehabilitation counselors for their responsibilities in relation to aides or other support personnel. There should be continuing examination and reappraisal of the evolving role and responsibilities of the rehabilitation counselor in the State rehabilitation agency and the setting in which he is employed in order to determine the adequacy of his professional preparation and to develop appropriate continuing education experiences necessary for working with the behaviorally disordered client.

Special steps should be implemented to recruit larger numbers of promising persons into careers in the rehabilitation field, including an effective network of communication between those who produce trained

personnel and those who use them. There is need for special recruitment measures directed to minority groups and other economically deprived persons, and greater State agency emphasis on preparing more of their clients for positions in rehabilitation work with the behaviorally disordered.

THE OUTREACH CONCEPT

The poor, including the behaviorally disordered poor, tend not to seek out services. Therefore, it has been necessary to move toward the outstationing of professional personnel in poverty areas. This has been supplemented by the use of trained indigenous aides (as above). This has been combined with the multi-service agency concept in which professional personnel from a variety of agencies are housed together in low-income areas. The multi-service agency, for example, has been found effective in selected CEP, Model Cities, and CAP programs in addition to a variety of innovation, expansion and R & D projects in rehabilitation.

Summary

The category of behavioral disorder has been amplified in the 1965 Federal Regulation for rehabilitation agencies. It denotes those whose behavior, attitudes, language patterns, and values impede their vocational success. While such use seems to be an acceptable means of using the traditional DVR delivery system, it does require change in our counseling approaches.

The current counseling approach seems to be based upon underlying assumptions of questionable validity. Criticisms have been leveled against inappropriate use of the medical model, diagnostics, and middle-class conceptions of counseling, especially in light of less-than-ideal outcomes and chronic manpower problems in rehabilitation.

If the problems of the behaviorally disordered are regarded as defects in learning resulting in specific behavioral deficits, then some suggestions emerge for new directions in rehabilitation counseling--new counseling strategies--new models of conceptualization, new means of reaching clients, and new uses of personnel. This chapter has attempted to outline the scope of these issues and indicate some considerations in re-examining the work we do.

CHAPTER V

TRAINING

Introduction

In this section is discussed the training needed by counselors, aides, supervisors, and administrators to enable rehabilitation agencies and staff to work effectively with behavioral disordered clients. Included is a rationale for the need for training, some of the techniques which have been found to be helpful and effective, and illustrative material and guidelines to be used in the development of a training program. Behavioral disorders as a disability group represents a somewhat bewildering confrontation to rehabilitation agencies both in terms of potential numbers of clients, and in the presentation of value systems foreign to many staff members. It will be especially important that agencies seek to innovate as much as possible in developing more effective training techniques.

Experience to date would indicate that in contrast to the physically disabled, the behavioral disordered client may sometimes appear to the counselor as a rebel. His deviant behavior may cause him to push hard for what he wants, at times being brutally frank, or confronting the counselor with an irritating or demanding approach. A prolonged period of frustrating and often degrading experiences with helping agencies has only helped to reinforce these feelings within the client, and as far as the client is concerned, he is reacting normally to the problem situation.

There has been some tendency to lump behavioral disorders and the disadvantaged together as one diagnostic entity. This has resulted in a great deal of confusion. It is important that a training program establish a clear distinction between the two. For the purpose of this section, "disadvantaged" will be seen as social, economic, educational or cultural deprivation, while a "behavioral disorder" is a defect of the person's personality or character makeup which creates problems for him in living. The terms, behavioral disorder, character disorder, and personality disorder have essentially the same implication for vocational rehabilitation. The term behavioral disorder will hereafter be used. Clients accepted for services by vocational rehabilitation agencies will have a specifically diagnosed condition which has contributed to, or resulted in, a vocational handicap. Therefore, rehabilitation counselors, supervisors, and administrators need to possess a thorough understanding of

the types of behavioral disorders which may be diagnosed, and the implication of this type of disability in rehabilitation planning. The need for knowledge and understanding becomes even greater when, as may happen, a staff member recognizes some of these behavioral patterns within himself or his associates, and finds himself becoming defensive.

In the past, rehabilitation agencies have not been too concerned with contacting prospective clients. Most agencies had more clients than they could serve, and contact was considered primarily the client's responsibility. In fact, the client's initiative in effecting agency contact was often considered to be an indication of his motivation. Now, however, we must deal with a group of people whose very inability to establish meaningful agency contact is one symptom of their disability. Working with them will, therefore, require a new approach or at least a reassessment of techniques. For example, few people in this group can tolerate a long waiting period prior to the provision of services. This is one reason why they have not previously received services. Many of them are not interested in long range, abstract plans, but rather will accept only immediate, tangible services. This means that rehabilitation will not only have to develop an understanding of a new type of disability, but will also have to reshape its approach, its attitudes toward the delivery of services, and the way in which services are handled. It is not enough that these individuals, most of whom have already been seen by a variety of social agencies to little avail, be merely run through the rehabilitation machine, also to little avail. If effective services are to be actually provided, the counselor's preconceptions must be challenged, innovations attempted, and all efforts aimed toward one goal--the client's rehabilitation.

An adequate training program will strive toward the development of positive attitudes toward behaviorally disordered clients who are vocationally handicapped by instilling in the trainee (1) an understanding of the etiology or cause of the disorder, and (2) an understanding of the relationship between the disorder and the client's failure to find and maintain stable employment within his capabilities. In addition to a need for an understanding of behavioral patterns, the trainee will need to come to an awareness of different value systems which exist in our society, and that behavior is shaped to a great extent by the environment. An individual who has lived in a casual, non-working environment will not attach the same value to time as does the counselor who works by the clock, and to whom punctuality is essential. Character strength or weakness, or motivation, is not a factor in this evaluation. Rather, in this example, it would be important to assess the client's ability to change his behavior to fit into a "timed" culture. Any attempt to evaluate the client by the counselor's own cultural values might result in phrases such as passive resistance, poor motivation, etc.

Academic knowledge of behavioral disorders is not sufficient for the counselor whose attitude toward the client must convey acceptance, and who must, therefore, feel empathically the client's inability to express anger directly, or his fear of too much success, or his acceptance of failure before it occurs, etc. This ability to feel "with" his client will probably only occur after an emotional experience which elicits the similar depth of feeling in the counselor. A white counselor, for example, will probably never fully understand the anger or sense of futility of a black client until he, himself, has experienced rejection because of some factor over which he has no control. Similarly, an aggressive counselor who is comfortable in making decisions will have little patience with the client who is fearful of making decisions, until that counselor has experienced some similar emotional dilemma himself. Therefore, an adequate training program should attempt to create situations in which emotional confrontations can and will occur, and then relate these to the counseling role.

Techniques of Training

There are a number of ways in which training can be approached, depending upon the resources available. Each agency should experiment to determine the most feasible and effective for its own program. A first step is an objective analysis of the needs of the staff. This can only be accomplished by evaluating existing attitudes toward behavioral disordered applicants, existing knowledge, and the ability of staff to work purposefully with these clients. A simple survey might be an effective way to begin such an evaluation. (See the survey of State agencies discussed in Chapter III, and Appendix A.) Development of the actual training program can then be directed toward demonstrated needs, and built upon the resources available.

The customary information-giving classroom method may be useful if supplemented with such devices as role-playing, followed by interpretation and discussion. It should be remembered that the objective is emotional involvement to the extent that behavioral patterns and attitudes will come to the fore and can be discussed, not in a critical sense, but rather to aid the trainee to a better understanding of the feelings of his clients. Each of us has developed patterns of behavior which help us adapt to our environment, and an awareness of these patterns will make us more aware of the critical behavioral patterns of clients.

If the agency should have a psychiatric medical consultant available to work directly with the counselors, an effective training situation can be developed. Using counselors' cases as they are presented, the consultant will be provided the opportunity to discuss behavioral patterns and the

resulting vocational handicap, while concurrently confronting staff members who exhibit unaccepting attitudes toward these disability groups. The consultants will have the opportunity to offer instruction in the etiology of specific behavioral disorders, and thus improve the ability of staff members in obtaining pertinent social data. This approach to training has the advantage of keeping the focus on the client, and is, therefore, usually more acceptable.

Another type of training situation which has been found quite effective can be termed the group interaction approach, utilizing all professional staff, or a mixture of professional and support personnel (aides). If local residents, clients, or citizen groups can be involved, they can offer a tremendous amount of insight into local customs, etc. This type of group can be somewhat more threatening, since candor is invited, and indeed required, and the leader must, therefore, be a person not only trained and comfortable in group interaction, but one who also has some experience in the subject matter. Depending upon the situation, a professionally trained person should be used as a leader if at all possible. This approach has been found especially effective in developing an understanding of cultural values.

For a staff member who will deal with another ethnic group, a special type of training situation can be arranged to provide him with a minority experience. This might best be arranged with one of the several anti-poverty agencies engaged extensively with persons of minority groups and the disadvantaged. Here the trainee can spend several hours or days in a real situation, becoming familiar with ideas, values, speech, etc., all of which would have presented a barrier to his work with clients. Similarly, a training situation similar to the group interaction arrangement, in which the trainee is a minority of one, can be very informative. As in any group situation, the leader should possess a high degree of skill.

Guidelines and Case Histories

INTRODUCTION

It is not possible at the present time to lay down neat formulas for selecting those applicants with behavioral disorders who will benefit most from rehabilitation services. Our experiences have been too limited. The only way we can, in the future, guide our efforts in working with people with this disorder, is to move ahead, using our best judgments, and provide services to them to the extent that our funded resources will logically

permit. Then we should assess our results as we gain experience. The frequent and organized assessment of results is an essential part of any innovative program or expansion of services.

For these reason, the following guidelines are presented to assist in further interpretation of the Federal Regulations as they pertain to eligibility of applicants with this disability. Definitive guidelines for individual case selection, if such ever prove feasible, must await the accumulation and assessment of our experiences.

It should always be remembered that no applicant can be considered eligible for vocational rehabilitation services solely because he is identified with a particular problem group (e.g., public offenders, chronic drinkers, welfare recipients, disadvantaged, etc.). In every cases, there will be an individual evaluation. In this evaluation, the presence of a physical or mental condition (including behavioral disorder) as defined in the Regulations must be established. In addition, the relationship of this physical or mental condition to a vocational handicap must also be determined.

Suggested Questions and Guidelines for Evaluating Case Studies

1. Question: What do the statements in the Federal Regulations on "physical or mental disability" say about behavioral disorders?

Guidelines: Section 401.1(o) defines "physical or mental disability" to include "behavioral disorders characterized by deviant social behavior or impaired ability to carry out normal relationships with family and community which may result from vocational, educational, cultural, social, environmental, or other factors." Sections 401.32 (a), (b), (c) will consist of a comprehensive evaluation of pertinent medical, psychological, vocational, educational, cultural, social, and environmental factors in each case; that the diagnostic study will include, in all cases to the degree needed, an evaluation of the individuals' personality, intelligence level, educational achievement, work experience, vocational aptitudes and interestes, personal and social adjustment, employment opportunities, and other pertinent data helpful in determining the nature and scope of services to be provided, and that in all cases of behavioral disorders a psychiatric or psychological evaluation will be obtained, as appropriate.

2. Question: What is a behavioral disorder?

Guidelines: Individuals with a behavioral disorder will exhibit a condition or impairment distinguished by a persistent or long standing pattern of maladaptive behavior or inability to carry out normal relationships with family and or community. A behavioral disorder could be considered a manner of reacting to the environment which causes problems whether to the individual or to those around him. These problems might be observed in the home, in school, on the job, or in his social relationships, and the existence of such problems might be verified by observers such as teachers, employers, family, social workers, probation officers, police, and credit agencies. A behavioral disorder is not necessarily a medically diagnosable condition, since it may be diagnosed by either a psychiatrist or a psychologist, both of whom are professionally trained evaluators of human behavior. It is important to note that conditions such as cultural and social deprivation, chronic poverty, criminal activity, educational deprivation, and chronic unemployment, do not in themselves constitute a behavioral disorder, but rather describe situations which may result in or from a behavioral disorder. (See Chapter 16, Vocational Rehabilitation Manual.)

Some examples of behavior which would cause a counselor to suspect the existence of a behavioral disorder are:

- a. A persistent pattern of unemployment, public assistance, arrests, heavy drinking, use of drugs, and disrupted family and community relations.
- b. A persistent pattern of job instability, loss of jobs due to fighting or disagreements with fellow employees or supervisors, and other inappropriate work behavior.
- c. A persistent pattern of school truancy and vagrancy, education underachievement, and school drop-out.
- d. A persistent pattern of misdemeanors (petit larceny, assault, vagrancy, no-account checks, drunken driving, etc.), felonies (burglary, robbery, assault, forgery, grand larceny, etc.), incarceration, and persistent deviant social behavior.

It should be remembered that persistent is the key word. A behavioral disorder is a way of behaving as evidenced by a definite, predictable pattern. A loss of one or two jobs due to fighting can be circumstantial. A persistent, chronic, loss of jobs due to fighting becomes a behavioral pattern.

3. Question: Are all persons with disorders eligible?

Guidelines: To the extent that the basic eligibility criteria are met, i.e., an existing physical or mental disability (this includes behavioral disorder), a substantial handicap to employment, and a reasonable expectation that vocational rehabilitation services will render the applicant fit to engage in a gainful occupation, persons with behavioral disorders are eligible.

4. Question: Who can make the diagnosis of behavioral disorder for vocational rehabilitation?

Guidelines: The Federal Regulations state that "in all cases of behavioral disorder a psychiatric or psychological evaluation will be obtained, as appropriate" (401.32 (e) (2)). Beyond this, the Regulations are clear in reserving for the State agency the authority for setting standards for agency staff and for consultants utilized by the agency. This means, then, that although the Regulations require a psychiatric or psychological evaluation, each State is free to establish in the State plan the qualifications of the psychiatrist or psychologist acceptable to the agency. To the extent that the rehabilitation counselor meets the standards established in the State Plan for psychologists, for example, he might be qualified to perform the evaluation. However, other factors such as work assignment and caseload would have to be considered. In addition, resource personnel could possibly provide an element of objectivity in disability determination that might not otherwise be provided.

5. Question: How is the appropriate diagnostician for suspected behavioral disorder cases selected?

Guidelines: Where the State Plan sets the standards, the rehabilitation counselor working with the medical and or psychiatric consultation, if possible, would follow those standards in selecting a behavioral disorder diagnostician. Generally

the psychologist would be the appropriate individual to diagnose behavioral disorder, and the psychiatrist, mental illness. The psychiatrist may also perform the function of ruling out mental illness, per se, and at the same time establish a behavioral disorder diagnosis, if he finds this. This will require a considerable degree of cooperation and thorough understanding of the vocational rehabilitation program on the part of both the psychiatric and psychological consultants.

6. Question: What are the components essential in the diagnosis for eligibility determination?

Guidelines: In addition to the general medical evaluation, psychiatric or psychological evaluation, and other specialty examinations required by the Regulations, good casework practice would include reports from a variety of examiners and observers which would give many of the features of a pattern of behavioral disorder, if such exists. To the degree needed these would include personality evaluation, grade or educational achievement, work experience, vocational aptitudes and interests, social adjustment, etc.

7. Question: Who contributes the components?

Guidelines: Other sources beyond the usual medical, educational, and social reports can conceivably provide substantiating information to be useful in determining eligibility. Some of these might be probation and parole reports, employment records, family interviews, school records, etc. Collection of such information will be more time consuming, and may require the use of support personnel. However, this is just good casework practice, and will be found useful in every type of case.

8. Question: What is the role of the medical consultant in serving clients with behavioral disorders?

Guidelines: The medical consultant has a major role with the counselor in evaluating all diagnostic reports and assessing their currency, applicability, adequacy, and implications. Requests for specialty examinations, physical restoration services, extended evaluation services, and feasibility of vocational goals should be jointly discussed. Periodic consultation regarding therapy progress, behavioral changes,

and medical suitability of the occupation is always a suggested practice. Since the behavioral diagnosis may be performed by a psychologist, a psychological consultant may also be deeply involved in evaluating non-medical reports.

9. Question: Are we mandated to serve persons with behavioral disorders?

Guidelines: Within the definition of "physical or mental disability" cited in Section 401.1 (o) of the Federal Regulations, the mandate to serve this disability group clearly exists. That no person may be denied services solely on the basis of disability is also clearly indicated.

10. Question: What are the implications in serving this group?

Guidelines: The prognosis, in terms of vocational rehabilitation, for this group may be guarded at the present time, since our experience is so limited. There will be increasing demands for service from correctional institutions and agencies. Public and private social welfare agencies may refer their previously unreferrable clients. Schools, employment agencies, anti-poverty programs, etc., will all be looking to vocational rehabilitation for solutions for their problem cases. The pressures on counselor time, and agency budget, will increase. By focusing a spotlight on this group, there may result better coordinated interagency programs, more people served more efficiently, improved techniques, and ultimately more disabled people gainfully employed.

11. Question: What are some of the changes agencies may have to make to extend services to this group?

Guidelines: It is difficult to be explicit in this type of question, since different populations require different approaches. However, experience from the several projects dealing with a preponderance of behaviorally disordered clients illustrates that the method of offering services is as important as the services, and in fact, unless the delivery system is acceptable to the applicants, they will never progress beyond the application stage. Several factors are significant.

- a. The rehabilitation intake process must be simplified, with immediate, tangible action meaningful to the client.

- b. More extensive involvement by the counselor. Many behaviorally disordered clients will not actively pursue help for themselves; doing so requires a drastic change in their way of living. Therefore, counselor and agencies may have to take a more aggressive role in seeking out and working with these people. Agencies may, for example, have to rearrange their office day, keeping the doors open from morning until late at night, etc. The applicant will have to feel accepted or he will not stay to become a client. This will require the cooperation of every staff member--from administrator to receptionist.
- c. VR must become closely involved with other agencies serving this group, such as O.E.O., C.E.P., correctional institutions, parole, etc., in order to profit from their experiences. The key factor is a closer sharing of services, so that the client will not feel pulled from one office to another, but rather supported and helped by all.
- d. Administrative and supervisory responsibilities will be increasing since the authority and responsibility for the development of new techniques lie with them. If the agency is to be truly effective, continued evaluation of the program, its scope, and effectiveness will be required.
- e. Counselor aides, particularly those closely associated with the particular clientele being served, may be the persons needed to offer the behaviorally disordered client the immediate attention, the assistance with small but important details, and the close follow-up he most requires. The client who might not be able to explain his problems initially to the professional, for fear of rejection, can often form a relationship with an aide. Refer to the IRS publication on Supportive Personnel, 1968.
- f. Agencies should not always require specific vocational objectives until clients are actively involved in the rehabilitation process.
- g. The behaviorally disordered client will tend not to see his difficulties as originating in his own maladaptive

patterns. Therefore, the counselor should strive to be as goal-orientated as possible in his discussion with the client, rather than placing emphasis on the use of diagnostic labeling as it relates to eligibility. The client sees only the results of his behavior, not the behavior, per se.

- h. Offices: It may be that small, unpretentious offices located near where the client lives, may reach some of the people who have previously been afraid to ask for services. Elaborate offices are sanctions associated with the lack of personal attention, especially by the client who has been passed from agency to agency.
- i. Projects: Agencies should familiarize themselves with innovative services being developed in other areas. Refer to Appendix D for a list of research projects.

Cases

CASE 1

Identifying Data: "Jane A" is a 22 year old single, Spanish American female who was born in a small mountain community in the southern part of the state. She is the fifth of eight siblings of whom two are still at home. The family structure is solid, but the resources are poor.

Referral Information: "Jane A" was referred by the State Hospital for counseling, therapy, and the supportive environment of the Rehabilitation Halfway House. There also was a need of occupational training.

Medical Information: The present diagnosis is sociopathic personality disturbance manifested by abnormal sexual activity and resulting in incarceration and hospitalization. "Jane A" has been hospitalized two times at the State Hospital previously for evaluation following pleas of insanity. She was found legally sane both times. She was given the final diagnosis of "sociopathic personality disturbance, dyssocial personality." Her physical examination was within normal limits.

Education: "Jane A" attended parochial school through the 8th grade then transferred to a public school where she completed the 9th grade in 1960. Her attendance was good, but her conduct, attitude, and use of time were considered poor.

Work History: She has been employed in domestic labor for short periods of time.

Present Economic Condition: "Jane A" has no present means of support. Her family cannot take her in, she is not eligible for unemployment compensation, and the Welfare agency has not considered her eligibility for services.

Psychological Data: While at the State Hospital, she was tested extensively and these tests indicated average intelligence, vocational interests in homemaking activities, and fair to good general aptitudes. The personality testing indicated that she is a socially retiring and highly insecure individual with tendencies to be irresponsible and impulsive.

On the basis of the information presented in the case study, do you feel that "Jane A" would be eligible for rehabilitation services? Yes _____ No _____ Do you believe this person would be eligible under the behavioral disorder classification rubric? Yes _____ No _____ Please discuss the reasons for your decision.

CASE 2

Identifying Data: "McC" is a 24 year old, single, Negro male, who was born June 19, 1942, in a community of 35,000 in the northern part of the State. He cannot return home because of a poor relationship with his father which tends to precipitate an emotional upset.

Referral Information: "McC" was referred by the State Reformatory. Asocial behavior, repeated incarceration, parole violations, and lack of employment with a need for guidance and therapy were reasons cited for referral.

Medical Information: The present diagnosis is sociopathic behavior in an individual with average I.Q. He has been admitted to the State Hospital on two occasions, both by court order. The initial diagnosis was personality pattern disturbance. The physical examination done on November 30, 1964, was within normal limits, visual acuity was 20/30 in both eyes, and hearing was normal. The mental status examination indicated the prognosis was given as fair to guarded depending on his response to treatment.

Education: "McC" began school at the age of six, finished the 8th grade in his home town with below average grades. He apparently was no problem in school.

Work History: He went to work when he quit school, worked as a common laborer, rough carpenter, and dishwasher. These jobs usually lasted less than six months and were usually terminated due to laziness, stealing, or fighting.

Present Economic Condition: No apparent source of support from family, Welfare, or other agency. Has small amount of savings acquired from hobby work done while in State Reformatory.

Psychological Data: Testing done at the State Hospital in 1960 gave him a WAIS FS I.Q. of 86 and other projective and personality testing resulted in an impression of personality pattern disturbance, schizoid tendencies.

On the basis of the information presented in the case study, do you feel that "McC" would be eligible for rehabilitation services? Yes _____
No _____ Do you believe this person would be eligible under the behavioral disorder classification rubric? Yes _____ No _____

CASE 3

Identifying Data: James C. is a 23 year old Negro, single male. Place of birth was Ardmore, Oklahoma. James has no dependents, is a U.S. citizen and has been a resident of this state for seven years. He is presently living with his parents and is in temporary seasonal employment as a car wash boy.

Referral Information: State Employment Service referred James to DVR after a recent application to them for services and after three unsuccessful job placements during the last 18 months. The last placement occurred at the time of referral.

Medical Information: This is not considered remarkable. Investigation did not result in verification of maternal statements concerning skull malformation. As a new-born infant, James had been kept in the hospital after mother's release due to premature birth. Client had the usual childhood diseases, fracture of left tibia at age 12. Neurological findings had been negative at age 16. There was no apparent physical disability. General medical examination showed all vital signs were normal and

client had no overt physical limitations. Complete neurological examination revealed a small focal lesion, left temporal lobe without current pathology. Sight and hearing were normal as were heart, lungs, limbs, etc. Client is 5'9" and weighs 160 lbs. Medical consultant recommended selective placement in same work as client previously performed without restrictions on heavy labor.

Education: Client completed 8th grade at age 16 with a poor academic standing. Grade records and anecdotal reports indicate social promotion. No additional formal training was reported since leaving school.

Work History: From time of school completion until age 19, client was not employed. He worked as a clean-up man and did minor service work in a service station for one year, which was followed by a six months' period of unemployment. He was next placed in an auto body shop preparing cars for painting. After ten months he left this and was placed in an auto rental agency, cleaning and servicing rental cars. After four months he was released from this position and placed with a similar company doing minor tuneup and car delivery. Six months later, he was again placed in a car rental service as a light duty mechanic, a job that he held for eight months before release because he did not perform the duties adequately.

Present Economic Condition: Client resides with mother who is on Welfare in a small, rented two-bedroom apartment. Client receives \$41 per week in wages. From this, he pays a \$98 per month car payment and provides personal needs. No other obligations were reported.

Psychological Data: WAIS full scale of 88 with the Raven results classifying James at the same level. No other tests were administered as the client's reading level would not permit use of those available. Stated vocational interests paralleled those demonstrated with the use of a Pictorial Vocational Interest Scale. Client also had a manifest interest in the automotive and mechanical areas, as observed in a Work Evaluation setting. School records provided no usable information.

On the basis of the information presented in the case study, do you feel that James would be eligible for rehabilitation services? Yes _____ No _____ Do you believe this person would be eligible under the behavioral disorder classification rubric? Yes _____ No _____. Please discuss the reasons for your decision.

CASE 4

Identifying Data: Mr. B is a 29 year old single male caucasian who was born in a small community in northern Utah. He was married for a brief time at the age of 23 but since has been divorced from his wife and now lives alone in a room in a Salt Lake City hotel.

Referral Information: Mr. B was referred to DVR by a probation officer who has been working with him as a result of a car theft incident. Mr. B describes the incident as "joy riding," not theft.

Medical Information: Previous history and medical examinations are not remarkable. Client had usual childhood diseases without residuals. He had one industrial accident that was minor; only involving a superficial laceration, without hospitalization. All vital signs are normal, vision 20/20 uncorrected both eyes, hearing is normal. Client is 5'11½" tall, weight 205. No abnormalities or pathology present. Examining physician indicates no employment limitations. He does state that client has potential for higher level occupation.

Education: B "almost graduated" from a small high school of about 350 students. The school records show no particular strengths and no particular weaknesses. The grades are uniformly C. He would have graduated from high school, he feels, except that during his senior year his widowed father remarried which caused some family dislocation that took him out of school.

Work History: Until he left school, B had no work experience other than incidental chores around the home. After leaving school, which was associated with the remarriage of his father, he was sent to Salt Lake City to live with some relatives. While in Salt Lake City he engaged in various kinds of inconsequential employment such as washing dishes and selling newspapers, but he seemed unable to stay on any job very long. For a short time he was in training with a photographer, but he showed no particular aptitude for this type of work so this was discontinued.

Present Economic Condition: B has been living in a small hotel room alone under the combined support of the Public Welfare Department and his father. He apparently has sufficient funds to meet his needs from day to day but has no reserve.

Psychological Data: The school records include several test scores. Intelligence as measured with the Henmon Nelson showed an I.Q. of 85. The Pressey Classification Test gave a percentile of 43, using general population

norms. Achievement tests showed B to be performing in general at a low average level. All GATB aptitudes were approximately one-half standard deviation below the mean.

On the basis of the information presented in the case study, do you feel that "Mr B" would be eligible for rehabilitation services? Yes _____ No _____ Do you believe this person would be eligible under the behavioral disorder classification rubric? Yes _____ No _____. Please discuss the reasons for your decision.

CHAPTER VI

THE BEHAVIORAL DISORDER CATEGORY: THE CHALLENGE OF CHANGING CLIENT POPULATIONS IN REHABILITATION

Service Delivery System

The trend to innovate and to develop new programs and the evaluation of the old: these have caused rehabilitation to be effective in the future. New rehabilitation techniques which are geared to the service needs of the behaviorally disordered are being given careful consideration by rehabilitation.

Many rehabilitation workers are beginning to feel that there are identifiable gaps in the current rehabilitation system which necessitate modification. The Statewide Planning projects undertaken by States to plan a rehabilitation system that will serve all handicapped persons, including the behaviorally disordered, by 1975 is one step forward in an attempt to close these gaps.

The traditional, middle-class oriented rehabilitation system may be challenged by the behaviorally disordered client who may come from a poor environment and be unmotivated for this system. What are the service needs unique to the behaviorally disordered? How do you motivate the behaviorally disordered towards utilizing rehabilitation services? Should new program objectives be developed and adopted for working with this particular group?

In modifying or developing a new rehabilitation service system for the behaviorally disabled, two major factors should be considered. First, the factor of building into the system opportunities for trial and error learning. Many behaviorally disordered clients lack adequate experience in a variety of work-related areas. They learn, but in a negative sense. In the first place, the behaviorally disordered have an expectation to fail, and when this is confirmed through the termination of a job or related activity, their self-concept is further damaged and they frequently withdraw. We need to provide a more permissive environment in the rehabilitation system for trial and error learning.

Secondly, we should give consideration to developing behavioral adjustment criteria for the behaviorally disordered. The major evaluation

criterion for client success in the current rehabilitation system is employment. As a result, virtually all the emphasis is placed in this area. Frequently no attention is directed to the behavioral changes that may take place while the client proceeds through the rehabilitation process, nor is he consistently rewarded for these changes. In working with the behaviorally disordered, we should recognize and reward the behavioral changes that take place. In modifying or developing an effective rehabilitation service system for the behaviorally disordered, rehabilitation workers and agencies should critically analyze the various work preparation and employment programs under the auspices of other public and private agencies. Many of the National Alliance of Business, MDTA, OEA, and Department of Labor programs have had considerable experience in serving people who would come under the behavioral disorder classification. Hence, rehabilitation agencies and workers can draw upon the experiences of these programs and abstract those components which will contribute to the development of an effective service delivery system in rehabilitation.

CLIENT PARTICIPATION IN REHABILITATION PROGRAMS DEVELOPED

Each client entering the rehabilitation process enters with a unique self-concept and value system based upon prior social, emotional, and cognitive learnings. These learnings are predicated upon such reality factors as the client's disability, age, prior educational attainment, economic position, family interrelationships, and his ecological and cultural background. The client's self-esteem and values not only have an important effect on the rehabilitation counseling process and outcome, but they also mediate the client's perceptions of the reality factors impinging upon him. Therefore, it seems that they should be more involved in rehabilitation program development. Both successful and unsuccessful clients have seldom been asked their feeling toward rehabilitation services.

More vocational rehabilitation agencies will implement the 1968 Vocational Rehabilitation Amendments which deal with the utilization of disabled persons in Statewide Planning Advisory boards and the New Careers Program. In reference to the latter, the handicapped have been for years and still are a major untapped advisory resource for rehabilitation.

MEASURES OF COUNSELOR PERFORMANCE

One of the evident problems which will inevitably affect the provision of rehabilitation services to the behaviorally disordered client is

the unwritten "closure requirement" of State vocational rehabilitation agencies. This requirement is used as a fundamental measure of counselor performance and effectiveness. As a result of this factor, coupled with other factors such as the long amount of time that may be necessary to rehabilitate the behaviorally disordered client, the unpredictability, and the lack of knowledge and experience with the behaviorally disordered client, rehabilitation workers may overtly or subtly resist working with this group. Should counselors who work with difficult clients and deliver a limited number of closures be penalized and viewed as an incompetent, ineffective employee? As pointed out by Muldoon (1968) rehabilitation has not seen itself as responsible for understanding the motivation of the difficult client so that it can adjust to him. We, therefore, may need to establish some new and different criteria of outcomes for clients and measures of counselor performance. Such a development would provide incentive for counselors desiring to work with the behaviorally disordered.

Mission of Rehabilitation

What changes will be made in vocational rehabilitation during the next decade? We know there should--and will--be many changes, but the nature and direction of those changes can be determined only by the people who live in each community, state, and in the nation. The kind and quality of decisions reached--and of changes that are made--may have a significant bearing on the future of the disabled members of our society.

Some of the changes that appear to be on the horizon for the field of vocational rehabilitation may seem to be pronounced departures from the present general pattern. This is not necessarily the case. Most of the changes have come about gradually, and trends--both in vocational rehabilitation and the society at large--have already started the transition. Changes could be accelerated by the public and rehabilitation workers who want to achieve greater adaptability of the vocational rehabilitation program to meet the challenges of contemporary and emerging society. It seems more likely that there will be slow evolutionary progress, and that new adaption will be essential by the time adjustments to present conditions are achieved.

Another factor that may inevitably affect the goals of rehabilitation in the future is the changing attitudes of society toward work. The significance of work in contemporary society is receiving increased attention. The technological changes in industry, eradication of many unskilled and semi-skilled jobs, consideration of developing guaranteed income, etc., have all influenced the attitudes of society toward the world of work. In view of this, and the fact that many of the jobs for which the disabled

will have job skills will be eliminated, should rehabilitation abolish its traditional goal of employment as the sole outcome of rehabilitation? Should rehabilitation develop some different criteria of success? What should be the boundaries of rehabilitation in terms of the people it intends to serve?

In recent years the social revolution in America has reached high proportions. It has stimulated the consciousness of many Americans in a negative and in a positive sense. The poor and various minority groups have actively challenged the traditional middle-class oriented public and private institutional systems in an effort to achieve equality of opportunity, social emancipation, and justice. They have issued the indictment that most public institutions display racial overtones. Some forms of racism are blatant. Other forms of racism are more subtle, such as standards of beauty, acceptable speech, the promises of advertising, and the quality of education--all of which are white. This indictment is of the total society and not just a segment of the society. The rehabilitation system is one of the institutions in American society that is vulnerable to this indictment.

In rehabilitation there are two basic assumptions underlying the formation of special programs for the handicapped: (1) every member of a democratic society has an inherent right to the opportunity to earn a living and make his contribution to society, and (2) society has the obligation to equalize, as best it can by special services, the disabled persons' opportunity to earn a living equal to the opportunity possessed by the non-disabled members of society (McGowan and Porter, 1967). Can rehabilitation workers help fulfill these obligations for the handicapped person who may be poor or come from a different culture? Should rehabilitation workers be concerned with rehabilitating those people who are handicapped not only economically, socially, and educationally, but also because of the negative attitudes of society which is manifested in their lack of contribution to the rehabilitation process? This poses a major problem in the case of the behavioral disorders. It is being asked to understand the feelings and values of the new people that it might help. Rehabilitation is charged to help the behaviorally disordered--the poor, the hardcore unemployed, the school and work dropout, the delinquent. Traditional values, assumptions and techniques which originate in a concern for a different socio-economic culture apply specifically and relevantly to this group, however irrelevant they may be to the middle-class. Moreover, it is imperative that rehabilitation workers make the commitment and become more involved in helping people who are oppressed because of social ills. It needs to become involved in more community action programs and projects, such as multi-purpose centers, pilot center and model cities programs. Moreover, the concept of interagency coordination and cooperation must become a reality if rehabilitation intends to serve the behaviorally disordered.

Attitudes of Rehabilitation Workers

Although attitudes are seldom mentioned among rehabilitation workers, they are probably the most critical factor in a successful adjustment of the behaviorally handicapped. Research shows that attitudes are formulated out of knowledge and experiences and are significantly influenced by the environment in which the person lives. Rehabilitation counselors need to understand these new clients, their cultures, styles of life, values, and attitudes, even though they may virtually have no accurate knowledge and experience in dealing with them. The lack of experience, in particular, often creates and perpetuates fear, anxiety, hostility, apathy and indifferent attitudes.

Many attitudes can be modified as a result of increased awareness, knowledge and exposure. Rehabilitation workers should actively seek information and experiences for a better understanding of people who would be classified as behaviorally disordered. Many can learn from experience and develop the necessary attitudes and sensitivities essential to helping these potential clients proceed through the rehabilitation process.

Man has two basic psychological needs. One is the need for self-esteem, i. e., for high self-evaluation, and the second is the need for social status, i.e., high evaluation by others (Wright, 1959). As a result of these two factors, people have a tendency to develop according to what we expect of them. The self-image of the behaviorally disordered client coming to rehabilitation workers for help is often deeply affected by the manner in which he is treated, the goals the worker sets for him, and the expectations he has of him. The attitudes rehabilitation workers may harbor about him will influence the success of their work with him. We must view the "whole" man and help eradicate the prejudices and misconceptions which are prevalent in our society.

In pursuit of information and experiences for a better understanding of behaviorally disordered clients, rehabilitation workers need to do the following:

1. Develop a sincere desire and commitment to help all clients regardless of their classification of disability and social problem.
2. Develop in their agency a library of books, papers and periodicals dealing with etiological, historical, and cultural factors of clients who would be classified as behaviorally disordered.

3. Learn and respect the language patterns of clients from various ethnic groups that he can adequately communicate with him.
4. Make every effort to individualize the delivery of rehabilitation services.
5. Have dialogues with a variety of behaviorally handicapped citizens.
6. Develop and participate in group training programs designed to deal with rehabilitation workers' attitudes toward various client groups.
7. Develop and participate in in-service training programs designed to help them gain knowledge and understanding of the behaviorally disordered client.
8. Start listening to what behaviorally disordered clients have to say about their needs and rehabilitation services.
9. Become involved in community action projects and other community activities in the economically and culturally deprived areas from which many of these clients will come.

The future requires new kinds of attitudes, particularly among rehabilitation workers, if they intend to meet their commitments in rehabilitating all handicapped persons by 1975, or thereafter.

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APPENDIX A

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APPENDIX A

INSTITUTE ON REHABILITATION SERVICES
STUDY GROUP III
Rehabilitation Counselor Training Program
University of Northern Colorado
Greeley, Colorado 80631

January 16, 1969

SUBJECT: Questionnaire Regarding Current Practices in Rehabilitating
Individuals with Behavioral Disorders

TO: Each State Director
Vocational Rehabilitation and/or Services for the Blind

Study Group III of the Insitiute on Rehabilitation Services has been assigned the task of developing guidelines for the identification of behavioral disorders and to devise more effective means for working with people classified as having behavioral disorders. As you know, the Institute on Rehabilitation Services is an arm of the "Council of States' Administrators." It is the stated purpose of the Institute on Rehabilitation Services to study those areas of concern assigned to it by representatives of the State Administrators.

In view of the charge given this Study Group, it is respectfully requested that the enclosed questionnaire be given immediate attention by either yourself or the person in your agency to whom you have assigned this aspect of your program. It is further requested that the questionnaire be completed and returned to the undersigned by FEBRUARY 4, 1969. Your attention to this matter will be most sincerely appreciated.

Yours truly,

Richard R. Wolfe, Ph.D.
University Staff Member
Study Group III

INSTITUTE ON REHABILITATION SERVICES
 Rehabilitation Counselor Training Program
 University of Northern Colorado
 Greeley, Colorado 80631

Date _____

Type Agency: General _____
 (Please Check One) Blind _____

STUDY ON BEHAVIORAL DISORDERS

Please use the following definition as your frame of reference in replying to the following questions regarding current practices in rehabilitating individuals with BEHAVIORAL as the PRIMARY disability.

"A behavioral disorder is present when, through an evaluation, it is determined that an individual's behavior significantly deviates from what is considered normal or that his ability to carry on normal relationships with family and community is significantly impaired."

"An individual with a behavioral disorder exhibits abnormal behavior which persists over a period of time and manifests itself in various settings such as in school, on the job, before the courts, and in the family. Such incidents and behavior as family quarrels, arrests, truancy, idiosyncracies, or mannerisms do not, in themselves, constitute a behavioral disorder but may be suggestive of the existence of such a disability."

PART I--GENERAL INFORMATION

1. Has your agency provided its staff with any guidelines for providing service to individuals whose primary disability is behavior disorder? Yes _____. No _____. If yes, please attach a copy of such guidelines when you return this questionnaire.
2. Please describe the approach your agency follows in obtaining psychological or psychiatric evaluations for this group.

3. How many clients with behavioral disorder as the PRIMARY disability were served by your agency in FY 1967-68? _____ %
 increase _____ or % decrease _____ over FY 1966-67?

Questionnaire, continued.

4. How many clients with behavioral disorder as the PRIMARY disability were rehabilitated by your agency in FY 1967-68? _____.
% increase _____ or % decrease _____ over FY 1966-67?

PART II--PROGRAMS SERVING INDIVIDUALS WITH
BEHAVIORAL DISORDERS

Please indicate, by checking under the block, YES, or the block, NO, of your agency is serving those individuals with behavioral disorders in each of the following situations.

<u>SITUATION</u>	<u>YES</u>	<u>NO</u>
1. General VR caseload	___	___
2. Special VR caseload	___	___
3. Neighborhood Service Programs	___	___
4. Concentrated Employment Projects	___	___
5. Cooperative Manpower Projects	___	___
6. Third-party agreements	___	___
7. Research and Demonstration projects	___	___
8. Expansion grant projects	___	___
9. Innovation grant projects	___	___
10. Special Manpower Development and Training Act Project	___	___
11. New Careers	___	___
12. Operation Mainstream	___	___
13. Neighborhood Youth Corps	___	___
14. Work Incentive	___	___
15. Job Corps	___	___
16. On-the-Job Training (State Employment Sec)	___	___
17. Opportunity Industries Center	___	___
18. Migrant Opportunity Services	___	___
19. Model Cities Projects	___	___
20. Human Resources Development Concept (State Employment Sec)	___	___
21. Labor Mobility Projects (U.S. Dept. of Labor)	___	___
22. Labor Education Advancement Program (U.S. Dept. of Labor).	___	___
23. Other Specific Projects (Please describe briefly)	___	___

Please feel free to use the remainder of this page, and the back of any pages to clarify any comments for the benefit of the Study Group.

Questionnaire, continued.

PART III--DELIVERY SYSTEMS

Please check (with an X) on the line provided the types of delivery systems used in your agency to serve those clients with behavioral disorders.

1. Traditional VR office with clients assigned to a counselor with a general caseload. _____
2. Traditional VR office with clients assigned to a counselor with a "special" caseload. _____
3. Decentralized branch, store front, offices in close proximity to residence of clients. _____
4. Multi-service centers, neighborhood service centers, etc. _____
5. Multi-disciplinary teams in VR offices. _____
6. Mobile teams of specialists and/or equipment to provide appropriate services in rural areas. _____
7. Utilization individuals indigenous to specific disability group (for example, using recovered alcoholics to work with alcoholics, exconvicts to work with public offender, etc.). _____
8. Other unique system(s). _____ Please describe:

Of the Delivery Systems checked above as used by your agency, please rank, in order of preference, as to which is the most effective.

_____	_____
_____	_____
_____	_____
_____	_____

Questionnaire, continued.

PART IV--RESOURCES

A. Please list the currently available resources (those available to your agency) to specifically serve clients with behavioral disorders.

B. Training. Record the number of staff involved, and title of training program(s) pertinent to those with behavioral disorders in which your staff participated in Fiscal Year 1967-68.

(1) What do you feel is the basic kind of content material in training that needs be given the counselor in order that he can do his job in working with the behaviorally disordered.

(2) What type training do you feel needs to be provided to administrators and supervisory personnel relative to the "behavioral disorder" category?

(Please attach any training guides, programs used, outlines, etc., that you may have provided in any of your training in the area of "Behavioral Disorders").

Questionnaire, continued.

PART V--NEEDS

What are the most urgent NEEDS of your agency in serving those individuals with behavioral disorders, other than staff and money? Please list these in RANK ORDER.

1.

2.

3.

4.

5.

Questionnaire, continued.

PART VI--BARRIERS

Other than money and staff, LIST IN RANK ORDER what are the most significant BARRIERS in your agency to serving those individuals with behavioral disorders.

1.

2.

3.

4.

5.

Please list any other factors you feel might be considered by the Study Group in dealing with the preparation of training guides for the category, Behavioral Disorders.

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APPENDIX B

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APPENDIX B
DELIVERY SYSTEMS

1. Traditional VR Office with clients assigned to a counselor with a general caseload 46 Agencies
2. Traditional VR Office with clients assigned to a counselor with a "special" caseload 38 Agencies
3. Decentralized branch, store front, offices in close proximity to residence of clients 19 Agencies
4. Multi-service centers, neighborhood service center, etc. 16 Agencies
5. Multi-disciplinary teams in VR Offices 13 Agencies
6. Mobile teams of specialists and/or equipment to provide appropriate services in rural areas 3 Agencies
7. Utilization of individuals indigenous to specific disability group (for example, using recovered alcoholics to work with alcoholics; ex-convicts 12 Agencies to work with public offenders, etc.)
8. Other unique systems 13 Agencies

Included among the unique systems reported were:

Counselor assigned to high school
Vocational Rehabilitation Wing in Mental Institution
Comprehensive Rehabilitation Center
Prison
Community Center operated by Salvation Army
Special Court Case Load Youth Group Home
Work Release Prison
Contact Advising Agencies
Vocational Rehabilitation Office in Mental Health Hospital
Correction Facilities
Penal Institution
Re-Education Program
Juvenile Offender

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APPENDIX C

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APPENDIX C

TRAINING PROGRAMS UTILIZED BY VARIOUS STATE AGENCIES

Title of Course

Institute for Behavioral Science
Inservice Training--Implications of P. L. 89-333
Psychiatric Rehabilitation Training Program
Georgia Rehabilitation Conference
Regional Conference on Behavioral Modification

Conference on Behavioral Disorders
Group Psychiatric Training
Transactional Analysis Conference
Institute on Group Counseling in Rehabilitation Process
Group Counseling and Therapy Symposium

Georgia 4th Psychiatric Institute on Group Behavior
Newly employed involved in orientation program exposed to Behavior Disorder
Institute: Rehabilitation Worker in Correctional Setting
Regional Staff conferences
Graduate courses on the Behavioral Disordered

Institute on Drug Use
Session on Group Homes for Juveniles
Juvenile Judges conferences
Courses on understanding alcoholism
Psychiatric Rehabilitation Counseling Internship

Conference on Working with the Alcoholic
Basic orientation on work study program
Supervising counseling training conference
MDTA & Correction Seminars
Juvenile Courts and Vocational Rehabilitation

Behavior Modification as a Rehabilitation Tool
Workshop on Development and Utilization of Work Samples
Workshop on Counseling and Guidance
Agency Conferences
Psychiatric Training

Mental Retardation Training Institutes
Staff Conference on Alcoholic Rehabilitation
Inservice Training
Seminar on Interviewing the Disadvantaged
Seminar on Social Rehabilitation of the Public Offender

3 short term workshops for working with Staff
Attended 2 sessions on Behavioral Disorders
Student attend sessions on New Morality Choice
4 day Institute on Relevance of Social Environment on Rehabilitation of
the Mentally Retarded

Institute on Behavioral Deficiencies
Institute on Mental Retardation
3 day Institute on Behavioral Disorders
Seminar on Alcoholism
Inservice Training on Behavioral Disorder

APPENDIX D

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APPENDIX D

LIST OF SPECIAL PROJECTS

Following is a list of Special Projects designed to extend services to disadvantaged groups, persons with deviant behavior, recipients of public assistance, etc. This list is not complete, but may assist in providing ideas for continuing program, development, and expansion in these areas.

List of Innovation Projects Related to Disadvantaged Groups or Persons with Deviant Behavior

- | | |
|--------------|---|
| Alabama: | "Cooperative project with family courts in the rehabilitation of young adult offenders in Montgomery." |
| Arkansas: | "Primary and auxiliary rehabilitation services for the public offender." |
| California: | "Program of VR services for narcotic addicts in the East Los Angeles poverty areas." "Program to use Synanon techniques to vocationally rehabilitate narcotic addicts." |
| Colorado: | "Assignment of a rehabilitation counselor to the Denver County Court to evaluate cases referred to the Diagnostic and Probation Center." |
| Connecticut: | "Program of VR services for jailed inmates." "Cooperative alcoholism and drug dependence project with Department of Mental Health." |
| Florida: | "Program of rehabilitation services for the group of NYC enrollees in the Florida Board of Parks Program." |
| Maine: | "DVR Coop. program with MDTA designed to prepare mentally retarded individuals with additional physical disabilities for suitable employment." |
| Michigan: | "Initiation of a comprehensive program of VR services for public offenders." |
| Missouri: | "Prototype program for VR services for the public offender." |

New Jersey: "An innovation project for the vocational rehabilitation of the drug addict in three counties."

Oregon: "Development of a program of VR services in a correctional reception and diagnostic center at the Oregon State Penitentiary."

Pennsylvania: "Program of VR services for public offenders at White Hill."

(Fact Book for FY 1969, SPPG, March 14, 1968)

List of Expansion Projects Related to Disadvantaged Groups and Behavioral Disorder

Arizona: "A program of VR services for alcoholic and public offenders."

Colorado: "Establishment of residential rehabilitation facilities for delinquent adolescents known to the Denver Juvenile Court."

District of Columbia: "Expansion of special placement effort in cooperation with the Public Employment Service." "Program of VR service for disabled court referred youth." "A coop. program for the vocational rehabilitation of alcoholics at the Rehabilitation Center at Lorton, Virginia." "Program to provide VR services in a pilot multi-service neighborhood center."

Georgia: "Expansion of VR services for the chronic drunk offender--Emory University, Atlanta."

Iowa: "Establishment of three halfway houses for alcoholics . . ." (In conjunction with a Statewide program being financed by OEO)

Kentucky: "Provision of VR for the Park Duvalle Neighborhood Center Project in Louisville."

Maryland: "Inner City Community Mental Health Services Program of Baltimore."

Ohio: "Cleveland Inner City Project--AIM--Action in Manpower, to provide VR services in the heart of the densely populated and poverty stricken ghetto area."

- Tennessee: "Expansion of rehabilitation services for those disabled individuals incarcerated within the State prison at Nashville." "Chattanooga Pilot City Project--assignment of VR staff at the Neighborhood Service Centers."
- Texas: "Park South Community Service Center--assignment of VR staff to the Dallas Neighborhood Service Center."
- Virginia: "Program of VR services for public offenders in Federal reformatory."
- Wisconsin: "A program to reach the inner-core vocational rehabilitation client in Racine." "Provision of VR services to adolescent public offenders in a forestry camp-school setting."

(Fact Book for FY 1969, SPPG, March 15, 1968)

Research and Demonstration Projects

The following listing of on-going and completed Research and Demonstration Projects is illustrative of rehabilitation efforts attacking various facets of the complex of problems found in poverty-stricken populations. These projects, directly or indirectly, related to serving disadvantaged or poverty groups. Reports usually may be obtained by contacting the grantee directly.

14 PROJECTS WITH DIRECT BEARING ON POVERTY

- RD-63 "The Vocational Rehabilitation Problems of Disabled Puerto Ricans in New York City" (New York University Medical Center).
- RD-534 "Community Action for Comprehensive Rehabilitation Services and the Establishment of a Pilot Evaluation-Referral Center" (Contra Costa Rehabilitation Council, Martinez, Calif.).
- RD-790 "The Role of a State Vocational Rehabilitation Agency in Solving Problems in a Depressed Area" (West Va. VR agency).
- RD-1215 "Work, Inc.: A Demonstration of Personal Adjustment and Intensive Placement Techniques with Difficult to Place Disabled People in an Area of High Unemployment Incidence" (Florida VR agency).

- RD-1310 "A Comparative Study of the Reduction of Dependency in four Low-Income Housing Projects: A Descriptive and Conceptual Introduction" (RRRI Monograph No. 4, Northeastern University).
- RD-1559 "A Project to Demonstrate the Role of State Vocational Rehabilitation Agency in Serving the Disabled Aged" (West Va. VR agency).
- RD-1642 "Development of Regional Resources for Rehabilitation Services in an Isolated, Depressed Area of the Appalachian Region" (Kentucky VR agency).
- RD-1439 "Vocational Rehabilitation Needs of Disabled Puerto Ricans in New York City" (Puerto Rican Social Services, Inc.).
- RD-1763 "Vocational Rehabilitation Needs and Resources in Eastern Kentucky" (Kentucky VR agency).
- RD-1763 "Attitudes and Social Characteristics of Vocational Rehabilitation Referrals" (Special Report)
- RD-1922 "Vocational Rehabilitation of Culturally Disadvantaged, Emotionally Disturbed Persons Featuring Indigenous Aides" (Columbia University, College of Physicians and Surgeons).
- RD-2089 "Vocational Rehabilitation in an Economically Depressed Area" (California VR agency).
- RD-2320 "Emergency Concentrated Services in a Rural Area (Mississippi Delta)" (Miss. VR agency).
- RD-2479 "Changes and Intervention in Urban Communities" (The Menninger Foundation, Topeka, Kansas).
- RD-2601 "Research and Occupational Judgments" (Puerto Rico Psychological Institute).

4 "CONCERTED SERVICES" IN PUBLIC HOUSING PROJECTS

- RD-1250 "A Family Approach to Concerted Services through Vocational Rehabilitation in Cooperation with Other Community Welfare Agencies in a Low-Income Public Housing Development" (Missouri VR agency).

- RD-1553 "Vocational Rehabilitation Services in a Concerted Services Project" (Contra Costa Council of Community Services, Walnut Creek, Calif.).
- RD-1621 "The Elk Haven Vocational Rehabilitation Unit" (Community Progress, Inc., New Haven, Conn.).
- RD-1851 "Vocational Rehabilitation Service in a Low Income Public Housing Estate" (Greater Cleveland Neighborhood Centers Association).

26 SELECTED DEMONSTRATIONS ON DISABLED
PUBLIC ASSISTANCE CLIENTS

Cooperative Projects with Public Assistance Agencies for the
Vocational Rehabilitation of Applicants and Recipients.

- | | |
|---|-----------------------------------|
| RD-1131 Salem, Oregon | RD-1333 Little Rock, Arkansas |
| RD-1185 Montpelier, Vermont | RD-1334 Houston, Texas |
| RD-1206 New Jersey | RD-1335 Charleston, West Virginia |
| RD-1253 St. Paul, Minnesota | RD-1338 Phoenix, Arizona |
| RD-1323 Tallahassee, Florida | RD-1417 Atlanta, Georgia |
| RD-1329 Lincoln, Nebraska | RD-1494 Boston, Massachusetts |
| RD-1332 Madison, Wisconsin | |
| RD-1513 "The San Antonio Rehabilitation-Welfare Report." | |
| "The San Antonio Rehabilitation Report on Curriculum Developed for Prevocational Evaluation-Adjustment Classes" (Special Report No. 1). | |
| "Prevocational Instructor Guide" (Special Report No. 2). | |
| "Prevocational Workbook" (special Report No. 3). | |
| RD-1514 Salt Lake City, Utah | RD-1644 Des Moines, Iowa |
| RD-1515 Springfield, Illinois | RD-1648 Austin, Texas |
| RD-1533 Harlan and Bell Counties, Kentucky | RD-1662 Beckley, West Virginia |
| RD-1534 Lawrence and Martin Counties, Kentucky | RD-1337 Santa Fe, New Mexico |
| RD-1639 Washington, D.C. | RD-1768 Columbus, Ohio |
| | RD-1834 Puerto Rico |
| | RD-1835 Puerto Rico |

OTHER PROJECTS ON REHABILITATION OF
DISABLED PUBLIC ASSISTANCE CLINETES

- RD-124 "Studies of Public Assistance Referrals to Vocational Rehabilitation."
Volume I: Administrative Effectiveness.
Volume II: Predicting Outcomes (University of Washington, Seattle, Washington).
- RD-218 "Project to Determine the Rehabilitation Potential in Individuals Served by Public Welfare and Health Agencies" (Department of Health, Puerto Rico).
- RD-789 "A Cooperative Residential Training Project for Mothers Receiving Public Assistance Grants for Aid to Dependent Children" (D. C. VR agency).
- RD-1119 "Early Referral: A Demonstration of Early Evaluation of Rehabilitation Potential of Public Assistance Recipients" (California VR agency).

9 EXAMPLES OF PROJECTS SERVING URBAN
DISABLED YOUTH AND ADULTS

- RD-771 "A Cooperative Program of Special Education--Vocational Rehabilitation: Bridging the Gap Between School and Employment" (Oklahoma VR agency).
- RD-829 "Vocational Readiness for Young Disabled Students in New York City" (New York VR agency).
- RD-889 "The SERV Project: A Program Serving Urban Retarded Youth" (Department of Special Education, Detroit, Michigan).
- RD-1067 "Increasing Parental Contribution to Work Adjustment for the Retarded" (United Associated for Retarded Children, Inc., Milwaukee, Wisconsin).
- RD-1075 "The Efficacy of a Prevocational Curriculum and Services Designed to Rehabilitate Slow Learners Who are School Drop Out, Delinquency and Unemployment Prone" (Champaign Community Schools, Champaign, Illinois).

- RD-1589 "Effectiveness of a Placement-Oriented Work Program for Mentally Retarded Adolescents and School Drop Outs" (Federation of the Handicapped, New York City).
- RD-1602 "Vocational Rehabilitation of Physically Handicapped and/or Mentally Handicapped Youth Being Served by a Special Youth Opportunity Center" (Lane County Youth Study Board, Eugene, Oregon).
- RD-1629 "Extension of Criteria of Eligibility to Include Socially and Culturally Deprived Disabled" (Wisconsin VR agency).
- RD-1884 "Educational and Vocational Development of Disadvantaged Handicapped Youth" (Jewish Employment and Vocational Service, Philadelphia, Pennsylvania).
- RD-1919 "Influence of Low Socio-Economic Class and Parent Participation in the Adaptation of Retarded Adults to a Vocational Rehabilitation Program" (Association for Help of Retarded Children, New York City, Chapter).

8 PROJECTS ON HIGH SCHOOL DROP OUTS

- RD-1423 "A Program for the Rehabilitation of Drop Outs: A Future for Jimmy" (Washington Urban League, Inc., District of Columbia).
- RD-1427 "A School Drop Out Prevention Project for Overage Promotees" (Goodrich Social Settlement, Bell Neighborhood Center, Cleveland, Ohio).
- RD-1429 "Helping Youth Pursue Opportunities: Guidelines for the Prevention of School Drop Outs" (Maine State Department of Education).
- RD-1431 "A Plan to Analyze and Implement the Holding Powers of Wyoming Schools for Handicapped Students" (Wyoming VR agency).
- RD-1432 "The Drop Out Pattern: Actual and Potential."
- "The Drop Out Pattern: Actual and Potential--A Second Look" (Follow-Up Study) (Union High School District No. 5, Milwaukee, Oregon).

- RD-1433 "School Drop Outs in Washoe County, Nevada" (Washoe County School District, Reno, Nevada).
- RD-1434 "Selected Demonstration on Problems of School Dropouts" (Portland, Oregon).
- RD-1505 "Alleviating or Correcting on-Direction and Dislocation of Handicapped Students" (Washington State VR agency).

7 PROJECTS ON JUVENILE DELINQUENCY

- RD-949 "Rehabilitation of the Young Offender: A Cooperative Program of Correctional Rehabilitation" (Oklahoma VR agency).
- RD-1240 "Vocational Rehabilitation in Juvenile Delinquency: A Planning Program" (Oklahoma VR agency).
- RD-1477 "Comparative Evaluation of Rehabilitation Program for Emotionally Disturbed and Delinquent Youth" (Youth Research, Inc., New York City).
- RD-1855 "Cooperative Program for the Alleviation of Juvenile Behavior Problems" (State Department of Education, Oklahoma).
- RD-2257 "Modeling: An Approach to Vocational Rehabilitation of Juvenile Offenders" (University of Washington, Seattle).
- RD-2291 "Development of a Vocational Rehabilitation Center for Handicapped Inmates" (D. C. Department of Corrections).

6 PROJECTS ON THE REHABILITATION OF SELECTIVE SERVICE REJECTEES

- RD-1645 "A Program to Demonstrate the Effectiveness of Vocational Rehabilitation Services to Selective Service Rejectees (West Virginia VR agency).
- RD-1653 "The Unfit Majority: A Research Study of the Rehabilitation of Selective Service Rejectees in South Carolina (VR agency).
- RD-1658 "Experimental Demonstration Project for Serving Selective Service Rejectees" (Georgia VR agency).

- RD-1659 "A Demonstration of the Effectiveness of Vocational Rehabilitation Services to Selective Service Rejectees" (Arkansas VR agency).
- RD-1679 "Determining Needs for State-wide Vocational Rehabilitation Services for Selective Service Rejectees in Rhode Island" (Rhode Island VR agency).
- RD-1792 "Rehabilitation Potential of Selective Service Rejectees, Providence, Rhode Island" (Rhode Island VR agency).

5 PROJECTS SERVING DISABLED INDIANS AND ALASKANS

- RD-810 "Vocationally Handicapped Montana Indians: Rehabilitation by College Education" (Northern Montana College, Havve, Montana).
- RD-823 "A Study of Applicable Rehabilitation Services and Community Participation in Rehabilitation Activities for Disabled Alaskans" (Maynard McDougall Memorial Hospital, Nome).
- RD-1213 "Cooperative Program for Rehabilitation of the Disabled Indian" (there are seven other technical reports) (Arizona State College, Flagstaff).
- RD-1661 "Provision of Rehabilitation Services to Handicapped Alaskans to Help Recover from the 1964 Earthquake and Tidal Wave" (Alaska VR agency).
- R.C.-20 "Alaska Native Rehabilitation Project: 1966 Interim Report" (U.S. Public Health Service, Alaska Native Health, Anchorage).
- "Stimulating Learning Motivation in Disadvantaged Groups: A Hospital School Demonstration Program for Alaskan Native Children" (1967 Special Report).

2 PROJECTS ON "SKID ROW" ALCOHOLICS

- RD-284 "Potential for Rehabilitation of Skid Row Alcoholic Men" (Volunteers of America of Los Angeles, Inc.).

- RD-616 "Alcoholic Rehabilitation Project: A Study of the Increasing Rehabilitation Potential of the Chronic Alcoholic in an In-Treatment Center" (The Salvation Army, Men's Social Service Center, San Francisco, California).

5 RESEARCH PROJECTS ON DRUG ADDICTION

- RD-1188 "A Demonstration of Vocational Rehabilitation Techniques Toward Drug Addicts" (Puerto Rico VR agency).
- RD-1280 "Use of a Rehabilitation House and Integrated Community Approach in the Post Hospitalization of the Addict" (Vocational Guidance Service, Houston, Texas).
- RD-1623 "Cross Cultural Study of Vocationally Handicapped Youth (who are addicted to narcotics in Chicago, D. C., and New York City)" (University of Notre Dame).
- RD-1945 "A Study of Drug Use and Vocational Handicaps" (University of Notre Dame).
- RD-2090 "Follow-up Study Methodology in Drug Addiction" (Texan Christian University).
 Volume I: Narrative Report.
 Volume II: Interview Report Supplement.

COLLABORATIVE PROJECTS TO TEST AND DEMONSTRATE THREE STRATEGIES FOR PROVIDING REHABILITATION SERVICES TO DISABLED FEDERAL PUBLIC OFFENDERS

State VR agencies, in cooperation with Federal prisons, parole and probation offices are conducting these projects in the following cities.

- RD-2077 Pittsburgh, Pennsylvania
- RD-2078 Atlanta, Georgia
- RD-2079 Coordinating Center for the Federal Offender Rehabilitation Program, Olympia, Washington.
- RD-2080 Austin, Texas.

RD-2081 Denver, Colorado.
 RD-2082 Chicago, Illinois.
 RD-2083 Springfield, Illinois.
 RD-2186 Tampa, Florida.

19 OTHER PROJECTS ON THE REHABILITATION OF PUBLIC OFFENDERS

RD-685 "Youth in Trouble: A Vocational Approach" (The Children's Village, Dobbs Ferry, New York).
 RD-1146 "Personality Characteristics of Rehabilitated and Non-Rehabilitated Alcoholic Recidivist Prisoners in California" (University of California, School of Public Health, Los Angeles).
 RD-1387 "Vocational Rehabilitation Services in a State Penitentiary System" (Oklahoma VR agency).
 RD-1507 "A Cooperative Rehabilitation Program with the Board of Corrections in Georgia" (Georgia VR agency).
 RD-1551 "The Application of Comprehensive Psycho-Social Vocational Services in the Rehabilitation of Parolees" (Minneapolis Rehabilitation Center).
 RD-1568 "Surgical and Social Rehabilitation of Adult Offenders (Part I)" (Montefiore Hospital and Medical Center, Bronx, New York).
 RD-1667 "Rehabilitation Training for Women Offenders" (New York City Department of Correction).
 RD-1709 "Research Points the Way to Rehabilitating Public Offenders" (South Carolina VR agency).
 RD-1832 "Vocational Rehabilitation of Mentally Disordered Offenders Under Laws Applicable in Washington, D.C." (Washington Center for Metropolitan Studies).

- RD-1839 "Planning Vocational Rehabilitation Services for Disabled Federal Offenders" (Washington State VR agency).
- RD-1985 "The Effects of Pre-Vocational Assessment and Vocational Exploration with Intensive Community Follow-Through on a Representative Sample of the Mentally Retarded and Juvenile Delinquency Residents of the D. C. Children's Center" (D. C. VR agency).
- RD-2045 "The Alcoholic Offender" (Multnomah County, Portland, Oregon).
- RD-2072 "A Feasibility Study for Vocational Rehabilitation of the Public Offender: The Recidivist Misdemeanants" (Centenary College of Louisiana, Shreveport).
- RD-2076 "Risk and Rehabilitation: A Study of the Fidelity Bonding of Former Offenders" (Institute for Study of Crime and Delinquency, Sacramento, California).
- RD-2427 "Work Release: Factors in Selection and Results" (Southern Illinois University, Carbondale).
- RD-2473 "Effectiveness of a Vocational Rehabilitation Program in a Maximum Security Prison" (New York VR agency).
- RD-2506 "Study of Work Furlough" (San Jose State College Foundation, California).
- R.C.-13 "The Scar Beneath" (A film demonstrating problems of disabled public offenders) (PHS, Communicable Disease Center, Atlanta, Georgia).
- R.C.-16 "A Vocational Rehabilitation Study of Prisoners, Probationers and Parolees" (Emory University, Atlanta).

OTHER PROJECTS OF INTEREST

- RD-1337 "Short Time Vocational Rehabilitation of OASDI Applicants" (District of Columbia VR agency).

RD-1883

"Work Inhibition and Rehabilitation" (Community Studies, Inc., Kansas City, Missouri).

Part I. Work Involvement and Self-Perceptions of Ex-Psychiatric Patients: An Exploratory Study.

(Part II will deal with identifying psycho-social characteristics of work inhibition; Part III will be concerned with modifying work inhibited patterns of behavior).

Following is a listing of special activities designed to extend services to the ghettos and other disadvantaged areas.

1. Neighborhood Services Program, Minneapolis. Supported by an SRS three-year grant of nearly \$250,000 to the Minnesota DVR. Purpose: To bring VR services into the neighborhoods where people need them. Departments of Labor, HUD, and OEO are participating.
2. Model Cities, CEP's Atlanta. Expansion grant approved for Georgia DVR to provide rehabilitation services to disadvantaged persons, especially those with dental, visual and related impairments, who live in or near the Atlanta Model Cities target area. Immediate purpose is to serve people enrolled in the Atlanta CEP. The Economic Opportunity Neighborhood Service Centers will recruit and refer; and VR will provide evaluation, counseling, physical restoration, and other rehabilitation services.
3. VR Applied to all Disadvantaged in an Area-Wood County, Wisconsin. This is a "saturation" services project where rehabilitation and other services are applied county-wide in a 5-year demonstration project. Entering the fifth year, this R & D project has augmented staffing and financial support. Services are provided to meet the needs of all disabled people as well as those with handicaps resulting from socio-cultural, economic, and educational factors. The county is largely rural with several small and medium size cities.
4. VR-School Program Utilizes Training Incentive Allowance-Richmond, Virginia. The Virginia VR agency and the Richmond Schools executed a cooperative agreement for a program to assist youth 16 to 18 who are slow learners, underachievers, retardates, physically disabled, emotionally disturbed, or young people with behavioral problems. In-school students and selected drop outs will be served. Operating

under the regular section 2 State-Federal program, the special school program will include training incentive allowances which gradually escalate from \$10 to \$25 a week and total \$190 for those completing the ten weeks of training.

5. VR-Welfare in Hawaii. State VR staff are assigned to welfare units, and plans are to strengthen Statewide VR-Welfare collaboration. The Expansion Project at Lanakila Crafts began on April 1. It will provide structured evaluation and group training in industry. Service Trades related to the expanding tourism business are stressed.
6. Services to Indians - South Dakota. The South Dakota VR agency has employed a South Dakota Indian, fluent in the Sioux language, and under an innovation grant, to serve the handicapped Indian population out of the Pine Ridge office space provided by the Tribal Council, and out of the agency's Rapid City office.
7. Inner-City Juvenile Delinquency Program - Providence. The Rhode Island VR agency joined with "Progress for Providence," a Model Cities agency, in a program for prevention of juvenile delinquency. Located in the South Providence community, the program is staffed by a psychiatrist, psychologist, rehabilitation counselor, social worker, all part time, and indigenous "Prevention Aides." Relationships established with school personnel, the pertinent VR counselors assigned to cover schools, other social agencies, churches, civic organizations, etc. The aim is early detection of emotional and medical problems and the provision of VR and other services to prevent personal, social, and vocational maladjustment.
8. Rural Disadvantaged - Greenville, Mississippi. Under the sponsorship of the Mississippi Research and Development Center, the State VR agency established a rehabilitation center on the grounds of the de-activated Greenville Air Force Base to serve a severely depressed area. The Ford Foundation contributed "State" funds to earn Federal RSA funds. The State Department of Public Welfare provides financial and case service support to families of people receiving vocational rehabilitation services from the facility. Clientele come from six Delta counties. The MRDC is negotiating to develop employment resources. The Employment Service agency will provide selective placement services. The facility includes 100 apartments for client families and quarters for 100 additional individuals. In addition, about 400 off-facility clients can be served.
9. VR in Detroit. The Michigan DVR is involved with the work of the National Alliance of Businessmen which has the support of Henry

Ford II to provide 45,000 jobs for individuals from the ghetto areas in Detroit A rehabilitation counselor is stationed in all four Community Action Centers; plans are to select four indigenous counselor aides; programs involve close coordination of VR, ES, Health Referral Services, and welfare workers VR staff are assigned to the developing Detroit Neighborhood Service Program.

10. Public Assistance Clients - Pennsylvania. In 1963, a joint program was launched by the Pennsylvania Bureau of Vocational Rehabilitation and Office of Public Assistance to provide rehabilitation services to persons receiving public assistance so that they could become self-sustaining citizens. The program is called PROJECT INDEPENDENCE. Using regular VR and PA financing, the program includes the assignment of 22 rehabilitation counselors to work full time in the County Board of Assistance offices. Referrals are made both from intake and from caseworkers. Twenty counties are involved in the project with counselors and caseworkers working together and utilizing other community resources such as the State Employment Service.
11. Disadvantaged, Delinquent Girls - New York. The New York VR agency, in cooperation with the Department of Labor is providing services to a resident population of socially disadvantaged, emotionally handicapped adolescent girls who are referred for rehabilitation by Family Courts following adjudication as delinquent, pre-delinquent, or victims of neglect, through a facility established at the Villa Loretto School.
12. VR Services to Disadvantaged in Oregon. An Expansion Grant to the Oregon DVR helps finance a Portland project to expand services to Multnomah County AFDC cases. Evaluation and other VR services will be provided. A revised cooperative agreement between the State Welfare Commission and DVR provides for a closer working relationship and greater services for welfare recipients. The DVR, Welfare agency and Portland area employers have proposed the establishment of the Portland Management Council for Equal Opportunity which will sponsor the Career Training Center and allied workshop activities. Industry will provide its expertise, supervision, training techniques, contract work, job opening information, and financial participation. The DVR and other SRS agencies will provide referral, counseling, and all necessary social and rehabilitation services. Services to disadvantaged persons will be further expanded by the establishment of the Southern Oregon Goodwill Industries which is an administrative umbrella for five autonomous workshop units in five small communities.
13. Poverty Rehabilitation Units - California. Special units for rehabilitation services are operating in twelve different poverty areas in

California. Six of these are a part of State operated multi-service centers. Six are operated solely by the Department of Rehabilitation. These are financed with the assistance of an Expansion Grant project called, "Outreach to the Disabled in the Poverty Area." The programs make heavy use of indigenous aides to provide for case finding, home visits to assess family members, and communication with all State and community resources.

14. Innovation Project in Seattle. An Innovation Grant project in the central city area of Seattle will develop special procedures to provide rehabilitation services to disabled people whose rehabilitation potential is difficult to assess or bring out because of cultural and environmental factors. Two rehabilitation counselors, four rehabilitation aides, with supporting clerical assistance, and medical consultant assistance, make up the team.
15. Atlanta Employment and Evaluation Center. Established in May, 1966 with OEO financing, the Center has been operated by the Georgia rehabilitation agency. Now financed by the Georgia agency and a variety of RSA and other Federal support. Provides working evaluation, medical examinations, casework services, vocational counseling, job training, and placement. Several Federal and local agencies cooperate in this program for indigent unemployed or under-employed persons residing in the five counties of the Atlanta Metropolitan area.
16. Rehabilitation of Female Offenders - St. Louis. For the past two years, the private non-profit Magdala Foundation has been helping female offenders with job placement, clothing, basic education, and temporary shelter in private homes. Recently the Foundation purchased the former Busch mansion to offer more intensive services in a halfway house setting. A new joint project was initiated between the Magdala Foundation and the Missouri VR agency. Intensive counseling, testing, job conditioning, training, grooming, homemaking, social skills, and family counseling will be offered in a homelike atmosphere to assist in the transition back to society. RSA participation includes a "Laird" grant to refurbish and remodel the residence and to acquire equipment, and an Expansion Grant to provide new staff.

APPENDIX E

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APPENDIX E

SELECTED CURRICULUM RESOURCES FOR ASSISTING REHABILITATION STATE DIRECTORS AND TRAINING OFFICERS IN PREPARING REHABILITATION STAFF TO WORK WITH BEHAVIORALLY DISORDERED CLIENTS

Alcoholism and Drug Addiction

FILMS

Center for Continuing Education, Film Library, University of Georgia,
Athens, Georgia.

BLOOD MONEY (B & W, 5 min.).
Pictures an alcoholic on skid row.

FAMILY AFFAIR (B & W, 12 min.).
Introduces five members of the alcoholic family and demonstrates
the characteristics they have in common.

SKID ROW (B & W, 12 min.).
A documentary description of life on skid row in Chicago.

Encyclopedia Britannica Films, Inc., 1150 Wilmette Avenue, Wilmette,
Indiana.

ALCOHOLISM (B & W, 22 min.).
Presents the case histories of three alcoholics; discusses their
problems, care, and rehabilitation (1962).

McGraw-Hill Book Company, Test-Film Division, Highstown, New
Jersey.

DAVID, PROFILE OF A PROBLEM DRINKER.

Psychological Cinema Register, Audio-Visual Aids Library, Penn-
sylvania State University, University Park, Pennsylvania.

PROBLEM DRINKERS (B & W, 19 min.).
An alcoholic's downfall and rehabilitation. Attempts to have
alcoholism recognized as disease. March of Time production
(Alcoholics Anonymous, Research Council on Problems of Alcohol,
and Yale School of Alcoholic Studies) (1947).

Smith, Kline and French Services Department, Smith Kline and French Laboratories, Philadelphia, Pennsylvania.

ALCOHOLISM: THE REVOLVING DOOR.

This film depicts the use of psychotherapy and drugs in treatment of acute alcoholics. Among the sequences are conditions on "Skid Row" and a meeting of Alcoholics Anonymous. Special reports are made by Dr. Dudley Miller, Director of the Connecticut Commission on Alcoholism, and by Dr. Marvin A. Block, Chairman of the American Medical Association's Committee on Alcoholism (1955).

JOURNALS

British Journal of Addiction. Published semi-annually by Foundry Press, Ltd., Brereton Printing Works, Brereton Rd., Bedford, England.

Journal of Studies on Alcohol. Published quarterly by the Rutgers Center of Alcohol Studies, New Brunswick, New Jersey.

Journal of the American Medical Association. Published weekly by the American Medical Association, 535 North Dearborn Street, Chicago, Illinois.

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TAPES

New York University Medical Center, Institute of Physical Medicine and Rehabilitation, 400 East 34th Street, New York, New York.

ALCOHOLISM (1 hour, 38 minutes).

By Mrs. Marty Mann, Ruth Fox, M.D., Stanely Gitlow, M.D., and Chester A. Swinyard, M.D.

Disadvantaged

BIBLIOGRAPHIC RESOURCES

References on Counseling Minority Youth.

Bureau of Pupil Personnel Services, California State Department of Education, Sacramento, California

Prepared by Ruth B. Love, Special Consultant for Counseling and Minority Youth.

Relating to Mexican Americans.

Los Angeles City Schools, 450 North Grand Avenue, Los Angeles, California.

A bibliography prepared by the Office of the Superintendent.

The Tyranny of Poverty.

The American Jewish Committee, Institute of Human Relations, 165 East 56th Street, New York, New York.

A selected bibliography of books, pamphlets, articles on community action, employment, economic and social problems.

FILMS

Anti-Defamation League, 315 Lexington Avenue, New York, New York.

CAST THE FIRST STONE (B & W, 42 min.).

Americans whose lives have been affected by prejudice and discrimination - Negroes in Los Angeles and Chicago, Puerto Ricans in New York, Jews in Detroit and Mexicans, Japanese and Chinese in the Midwest - describe their first-hand experiences.

Film Associates Educational Films, 11559 Santa Monica Boulevard, Los Angeles, California.

PORTRAIT IN BLACK AND WHITE (B & W, 54 min.).

This examination of black attitudes toward the white community and white attitudes toward the black was produced with the use of a nation-wide poll. CBS prepared a 45-minute questionnaire and interviewed some 1,500 people. The results of these interviews show peoples' attitudes and feelings on the race question to be both subtle and complex.

National Education Association, 1201 Sixteenth Street, N.W., Washington, D. C.

LEARNING FOR LIFE (B & W or Color, 29 min.)

New developments in adult education.

JOURNALS

The Journal of Human Resources. Published four times a year by Education, Manpower and Welfare Policies, University of Wisconsin Press, Box 1379, Madison, Wisconsin.

The Urban Review. Published bimonthly by the Center for Urban Education, Bureau of Research, U.S. Office of Education, Department of Health, Education and Welfare, Washington, D. C.

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Young, Whitney M. Assuming--or evading?--Responsibility for added opportunity. J Rehabil, 1967, 33, 15-18.

TAPES

Center for Research on Utilization of Scientific Knowledge, Institute of Social Research, University of Michigan, Ann Arbor, Michigan.

Six training units on the World of Troubled Youth for the use of professional, volunteer and student groups. The purpose of each unit is to challenge, inform, and most of all, stimulate, inquiry so that the basic theories of social change and social action presented can be applied to the problems that are the special concern of the participating groups. Consists of records and discussion manuals. Published by Addison Wesley Publishing Company.

Center for the Study of Democratic Institutions, Tape Catalog, Box 4068, Santa Barbara, California.

THE CRISIS OF IDENTITY IN A WORKLESS WORLD (45 min.).

Judd Marmor, M.D., of the UCLA school of Medicine, suggests that in its studies of the technological order the Center for the Study of Democratic Institutions has given too little attention to the psychological dislocations that will occur in a workless world. Also participating: Linus Pauling, W. H. Ferry, Paul Jacobs, and Hallock Hoffman of the Center staff, and Roderic Gorney, M.D., Los Angeles psychiatrist.

THE BLEAK OUTLOOK: JOBS AND MACHINES (60 min.).

Gerard Piel, Robert Theobald, and Ralph Helstein take as their theme H. G. Well's statement: "The inertia of dead ideas and old institutions carries us on towards the rapids." An incisive, revealing conversation.

National Audio Tape Catalog, National Center for Audio Tapes, Bureau of Audio Visual Instruction, Stadium Building, Room 320, University of Colorado, Boulder, Colorado.

A repository of over 5,000 tapes, including many related to vocational rehabilitation, minorities, negroes, community organization, social problems, prejudice, etc.

Public Assistance

FILMS

Audio-Visual Aids Service, Concordia Publishing House, 3558 South Jefferson Avenue, St. Louis, Missouri.

111TH STREET (B & W, 32 min.).

A study of welfare workers as they work with the "street groups" of our urban areas. This film will bring the problems of a large segment of our population to the attention of many who may be able to help in one way or another.

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Weiss, Carol H. Validity of Interview Responses of Welfare Mothers. New York: Bureau of Applied Social Research, Columbia University, 1968.

Public Offender and Juvenile Delinquency

FILMS

Berkshire Industrial Farm, Canaan, New York.

MIRROR IN THE MOUNTAINS (B & W or Color, 19 min.).

The story of a youth sent to Berkshire Industrial Farm at Canaan, New York. Describes the work of Berkshire and how the youth is transformed into a useful citizen.

Center for Continuing Education, Film Library, University of Georgia, Athens, Georgia.

THE PERFECT SET-UP (21 min.).

Traces, through court records, the criminal career of a young man.

THAT BOY JOE (20 min.).

The story of juvenile delinquency.

CHILDREN IN TROUBLE (10 min.).

Seriousness and cost of juvenile delinquency and crime; causes of crime and effective methods of prevention.

International Film Bureau, 322 South Michigan Avenue, Chicago, Illinois.

YOUTH AND THE LAW (B & W, 36 min.).

Role of police working with community organizations to prevent juvenile delinquency, guide youthful energies. Importance of coordinating law enforcement with professional guidance for young people. How juvenile law should correct offenders, not punish them.

National Educational Television Film Service, Audio-Visual Center, Indiana University, Bloomington, Indiana.

CRIME UNDER TWENTY-ONE (B & W)

Criminal behavior of teen-agers. State that juvenile delinquency may be over-exaggerated. How improvements in statistics, reporting, apprehension influence total picture of teen-age crime. Group of young people discuss themselves. their problems.

CRIME IN THE STREETS (B & W, 60 min.).

About 50% of all serious crime in the streets is committed by boys under eighteen. This film examines two aspects of juvenile crime: the quality of police protection and the programs for rehabilitation of offenders.

Southern Illinois University, Learning Resources Service, Carbondale, Illinois.

THE ODDS AGAINST (B & W, 32 min.).

Focusing on one offender, this dynamic documentary film explores correctional systems in the United States today: detention, probation, imprisonment, parole. Contrasts are seen between older institutions and up-to-date facilities and programs throughout the country.

A PLACE IN THE SUN (B & W, 14 min.).

A former prisoner, considered rehabilitable, is sent to an honor farm and put to work eight hours a day. Here the young man is given farming educational opportunities, work experience with a road building gang and good recreational facilities.

THE ETHNOLOGICAL CRIMINAL (B & W, 30 min.).

Discusses the relationship of crime to race, national origin and minority groups. Points out patterns of belief and the misconceptions that exist. Relates living conditions and geographical distribution to crime. Concludes that race is irrelevant to criminality.

CULTURE AND CRIME (B & W, 30 min.).

Analyzes patterns of culture and how they influence rise of criminality. Uses the Nazi regime in Germany as an example. Points out how accepted behavior in one culture may be a crime in another. Discusses the impact of cultures meeting head-on thus giving rise to criminal behavior.

THE ALCOHOLIC CRIMINAL (B & W, 30 min.).

Discusses alcohol as a measurable cause of crime. Uses

filmed sequences and dramatic episodes to show how alcohol breaks down inhibitions, provides a sense of false security, and impairs judgment. Points up the relationship between alcohol and traffic accidents.

TEA, HORSE, AND CRIME (B & W, 30 min.).

Discusses the basic narcotic drugs and their relationship to crime. Includes a filmed sequence of an addict undergoing withdrawal and receiving a shot that assuages him. Points out that crime committed by the drug addict is a secondary effect.

I.Q. AND CRIME (B & W, 30 min.).

Discusses and refutes some often-heard ideas about the relationships between mental ability and crime. Presents interviews with two delinquents--one high, one low, in mental ability. Each interview is followed by a discussion of the case.

SICK MINDS AND CRIME (B & W, 30 min.).

Discusses the relationship of mental illness to criminal behavior. Emphasizes the functional disorders to schizophrenia, paranoia, and manic-depressive psychoses. Shows an interview with a schizophrenic type and compares him to persons suffering other psychiatric disorders. Presents brief episodes with a "normal" criminal, a psychopath, and a mentally deficient person. Demonstrates their reactions to situational demands.

NARCISSUS, OEDIPUS AND CRIME (B & W, 30 min.).

Presents an analysis of two potentially dangerous stages of psychosexual development. Uses filmed sequences to point out influences which result in fixations at these two stages. Projects their effects upon crime emphasizing the development of the psychopath and sociopath.

THE ROOTS OF CRIMINALITY (B & W, 30 min.).

Retraces psychosexual development patterns of personality emphasizing the psychopath and sociopath. Employs a series of vignettes to illustrate lack of affection, paternal rivalry, sibling rivalry, over-protection, and other child development influences. Points out potential future effects of these influences with respect to criminality.

THE CRIMINAL AND PUNISHMENT (B & W, 30 min.).

Discusses the concept of punishment of criminal behavior. Explains the evolution of rehabilitation with emphasis upon the criminal rather than the crime. Presents a visit to a cell block in San Quentin Prison where five actual inmates are interviewed.

THE CRIMINAL AND HOW TO NEUTRALIZE HIM (B & W, 30 min.).

Discusses the need for a constructive program for criminal rehabilitation. Points out that a true correctional philosophy has not been formulated. Illustrates with a scale model of an ideal correctional system. Stresses the desirability of a program for convict evaluation and subsequent treatments.

University of Minnesota, Audio-Visual Center, Minneapolis, Minnesota.

STEP BY STEP (B & W, 20 min.).

How social workers in New York City were able to make contact with juvenile gang members, gradually gained their acceptance, and helped guide young people away from delinquency.

JOURNALS

American Journal of Correction. An official publication of the American Correctional Association, published by W. T. Coulter, 2642 University Avenue, St. Paul, Minnesota.

Correctional Research. Published irregularly by United Prison Association of Massachusetts, 33 Mt. Vernon Street, Boston, Massachusetts.

Crime and Delinquency. Published in January, April, July, and October by the National Council on Crime and Delinquency, 44 East 23rd Street, New York, New York.

Crime and Delinquency Abstracts. Published irregularly by the National Clearinghouse for Mental Health Information, National Institute of Mental Health, Chevy Chase, Maryland.

Federal Probation. Published quarterly by the Administrative Office of the United States Courts in cooperation with the Federal Bureau of Prisons of the United States Department of Justice, Supreme Court Building, Washington, D. C.

Inscape. Published bimonthly by Center for the Study of Crime, Delinquency, and Corrections, Southern Illinois University, Carbondale, Illinois.

Psychiatric Spectator. Published monthly by Sandoz Pharmaceuticals, Hanover, New Jersey.

SK & F Psychiatric Reporter. Published bimonthly by Smith, Kline and French Laboratories, 1500 Spring Garden Street, Philadelphia, Pennsylvania.

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School Dropout

FILMS

McGraw-Hill Book Company, Film Division, 330 West 42nd Street, New York, New York.

PROBLEM OF PUPIL ADJUSTMENT: THE DROP OUT (B & W, 20 min.).
The importance of a life adjustment program in the school curriculum to meet the needs of teenage dropouts.

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Los Angeles State College, Rehabilitation Counselor Training Program,
5151 State College Drive, Los Angeles, California.

DROPOUTS - Michael Goldstein

IMPLICATIONS OF TODAY'S RESEARCH FOR TOMORROW'S
YOUTH - Friedenber

THE SCHOOLS OF TOMORROW - Goodland

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APPENDIX F

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APPENDIX F

PLANNING COMMITTEE CHARGES TO STUDY GROUP

TOPIC

Behavioral Disorders and the Disadvantaged.

PURPOSE

The purpose of this Study Group is to develop guidelines for the identification of behavioral disorders and to devise more effective means for working with people classified as having behavioral disorders.

CHARGES

1. Describe and define any relationship between behavioral disorder and the culturally deprived.
2. Define the role of vocational rehabilitation in current social action programming. Clarify VR's role with other manpower sub-systems.
3. Assess and describe the population to be served in terms of characteristics and numbers. Make recommendations as to which groups or sub-groups should be served.
4. Clarify the issues in eligibility of the culturally deprived. Is eligibility to be determined on the basis of societies' problems or on individual problems?
5. Assess the types of service being provided to the behaviorally impaired and recommend any appropriate modification of delivery systems.
6. Evaluate the appropriateness of the present diagnostic model for determining eligibility.
7. Describe or determine the rehabilitation needs of the population as defined.
8. Estimate the economics and staff support which will be necessary to serve this group.

SUGGESTIONS

1. Review the material collected and prepared by the 1967 IRS Committee on Selected Aspects of Eligibility, as it pertains to the behavioral disorders.
2. Consider vertical and horizontal expansion of services such as is being explored in the Wood, County, Wisconsin, Project.
3. Review RSA projects for serving the disadvantaged--the University of Missouri will make available all project reports they consider to be relevant.
4. Review the proceedings of the Invitational Institute on Rehabilitating the Culturally Deprived held at Mankato State College--fall, 1967.
5. Compile and synthesize the research information from Northeastern University and other Regional Research Centers studying dependency.

COMMENTS

The Planning Committee is fully cognizant of the tremendous scope of this area of study and it is not anticipated that the study committee will be able to study all of the charges in detail. At the same time, because the topic has such breadth, the planning committee did not feel it should prescribe priorities in listing the charges. It is the feeling of the Committee that while an indepth study of some of the charges may be necessary and desirable, a more generous treatment of the broad issues would be of inestimable value.

APPENDIX G

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APPENDIX G

ROSTER

IRS Study Committee on Rehabilitation of Individuals with Behavioral Disorders

*Indicates member of the Prime Study Group

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ADDENDUM

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DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE
SOCIAL AND REHABILITATION SERVICE
Rehabilitation Services Administration

(COPY)

Date: August 17, 1970

Reply to

Attn of: RSA/DSPA (Edward Newman)

Subject: Psychological Evaluations in Cases of Mental Retardation and Behavioral Disorders

To: Associate Regional Commissioners (RS)

Boston
New York
Philadelphia
Atlanta
Chicago

Dallas
Kansas City
Denver
San Francisco
Seattle

1. From time to time questions have arisen regarding psychological evaluation in cases of mental retardation and behavioral disorders, and in the determination of eligibility for and provision of services under the disability of behavioral disorders.

2. The attached memorandum was prepared in response to specific questions on these topics asked by the Region III office. Because of the general interest in these topics, we are forwarding to you a copy of the response prepared for Region III.

3. Your comments will be appreciated.

(Original signed by William M. Eshelman for)

Edward Newman
Commissioner

Attachment

UNITED STATES GOVERNMENT

Memorandum

(Copy)

TO : Associate Regional Commissioner (RS)
Charlottesville

DATE: August 14, 1970

FROM : RSA/DSPA (Edward Newman)

SUBJECT: Psychological Evaluations in Cases of Mental Retardation and Behavioral Disorders - Your memos of May 6 and June 23, 1970

1. Three issues seem to be posed: 1) the criteria for determining what constitutes a "valid test of intelligence," or an adequate psychological evaluation, 2) the qualifications of the person performing psychological evaluations, as required by the Vocational Rehabilitation Regulations in cases of mental retardation and behavioral disorders, and 3) the use of extended evaluation as a mechanism for providing services before psychological testing is completed.

Issue One-- Content and Technique of Evaluation

2. Neither the Federal Regulations (Section 401.32(e)(1), and 401.32(e)(2)) nor Federal Manual material on eligibility (Chapter 16, Section 1) requires any specific tests or technique of testing in cases of mental retardation or in cases of behavioral disorders. In requiring a "valid" test of intelligence in cases of mental retardation, the Vocational Rehabilitation Regulations are merely pointing to those generally held concepts of test construction that relate to the ability of the test to actually measure what it purports to measure.

3. The reference in the Virginia materials to Manual Chapter 13, Section 2, must be considered in its full context, specifically the entire paragraph in which it appears:

"It is the behavioral component of mental retardation rather than the measured intelligence quotient which is more meaningful in determining the individual's need for vocational rehabilitation services as well as his ultimate employment potential on the completion of such services. At the same time, it must be realized that the IQ can be of great importance to the counselor, especially in evaluating his client's readiness for academic training. The IQ should be obtained on the basis of an appropriate individual intelligence test administered by a qualified psychologist in all cases where the existence of mental retardation is suspected."

4. In cases of behavioral disorders, the Vocational Rehabilitation Regulations require a "psychiatric or psychological evaluation" (Section 401.32(e)(2)). No reference is made to content or techniques of this evaluation. In the context of the State-Federal program of



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vocational rehabilitation, "behavioral disorder" is a disability for which maladaptive actions or behavior are the predominant symptoms rather than an impairment of contact with reality or emotional distress typically associated with psychoses or neuroses.

5. The individual with a behavioral disorder is thus seen as one who cannot cope with the demands of family, vocation, or society, and whose incapacity is revealed by his pattern of social behavior or his impaired ability to carry out normal effective relations with family or community. The presence of a behavioral disorder may be determined only after a psychiatric or psychological evaluation which indicates that the individual's ability to cope with these demands is impaired, as shown by a pattern of maladaptive behavior.

6. Probable causes for the observed behavior are not at issue in determining that a behavioral disorder is present (though such may be highly significant in development of a rehabilitation plan); the basis for this determination rests on the unique pattern of behavior exhibited by the individual, and the manner in which the behavior interferes with his ability to perform in a gainful occupation.

7. Persons performing the required evaluations may not be cognizant of the intent and meaning of the rehabilitation use of the term "behavioral disorder," and hence, may fail to specify a diagnostic label. In such cases, the rehabilitation counselor, in relating the case record to the three criteria of eligibility, may determine, in accordance with procedures established by the State agency supervisory or consultant staff, that a behavioral disorder does in fact exist, within the intent of the Vocational Rehabilitation Act and Regulations. This decision will be indicated by the execution of a Certificate of Eligibility, and may be made only if the required psychiatric or psychological evaluation has been obtained.

8. Choice of test instruments or techniques must always be done in consideration of the use to be made of the information thus obtained. Brief tests, and a review of existing information (school records, etc.,) may often provide adequate information on which to base a decision of eligibility; however, principles of sound plan development require additional information, which may include more comprehensive individualized testing.

Issue Two - Qualification of Evaluator

9. In regard to persons performing the required evaluations, either for cases of mental retardation, or in cases of behavioral disorders, the State agency is authorized by the Vocational Rehabilitation Regulations to establish the qualification standards for personnel utilized in the rehabilitation program, whether in the employ of the State or for the purchase of vocational rehabilitation services (Section 401.42). For each major professional field represented by personnel providing services to handicapped individuals the State agency must describe the general nature of the minimum qualifications established, and must state the basis on which they were developed.

10. The State agency may utilize State examining or licensing boards in the formulation of standards, though this is not a Federal requirement. In the absence of any specific legislation in the State requiring reference to licensing or examining boards, the State agency should, nevertheless, set standards as high as is feasible, and yet which allow provision of needed services.

Issue Three -- Use of Extended Evaluation

11. Thus, most of what the Virginia agency proposes is within the scope of State agency decision. However, the use proposed for extended evaluation is at variance with the intent of and rules governing extended evaluation (Section 401.31 of the VR Regulations). Extended evaluation is to be used only in those situations in which there is inadequate data on which to base a decision regarding the probable outcome of the rehabilitation plan. Extended evaluation permits an observation of the individual's ability to respond to services, but it is not to be applied prior to, or as the basis for determining, the existence of a disability and a vocational handicap. Extended evaluation status is meant for those persons for whom it is clear that a disability and a vocational handicap exists, but there is some doubt on potential to become rehabilitated as a result of services.

12. That part of the Vocational Rehabilitation Regulations which deals with case study and diagnosis states:

"The State plan shall provide that, prior to and as a basis for formulating the vocational rehabilitation plan for any individual certified as eligible under s 401.30, there will be a thorough diagnostic study, which will consist of a comprehensive evaluation of pertinent medical, psychological, vocational educational, cultural, social, and environmental factors in the case. The State plan shall provide the basis for (1) establishing that a physical or mental disability is present; (2) appraising the current general health status of the individual; (3) determining how and to what extent the disabling conditions may be expected to be removed, corrected, or minimized by physical restoration services; and (4) selecting an employment objective commensurate with the individual's interests, capacities, and limitation." (Section 401.32(a))

13. This section makes clear the multiple purposes of the case study and diagnosis, places in perspective the amount of information required to establish eligibility in comparison to the more comprehensive information required to develop an adequate rehabilitation plan, and indicates that much of required evaluations may be secured after eligibility is established. This includes evaluations made pursuant to Section 401.32 (e)(1) dealing with mental retardation, and Section 401.32(e)(2), relating to behavioral disorders. Note that more comprehensive data is required

before placing an individual in extended evaluation than is required before establishing eligibility (Section 401.32(f)). This stems from the basis concept of extended evaluation: that all available information is insufficient to make a decision regarding the third criterion of eligibility.

14. In consideration of those portions of the Regulations relating to establishment of eligibility and extended evaluation, it would seem that the preferred course would be to develop the amount of information required to establish eligibility, accept the person for services, and conduct additional testing during plan development or concurrent with the provision of initial services. Extended evaluation would then be retained for those cases for which it was intended: Cases in which available data are inadequate to allow a judgement regarding the third criterion of eligibility.

/s/

Edward Newman
Commissioner